

Graduate Management Project: The Development of Medical Readiness
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Abstract

The Navy Medical Department is improving its governance structure and implementing broad directional strategies to position itself at a strategic advantage in the development of medical readiness. This is being accomplished by addressing new operational concepts in joint doctrine amid recent outside concerns. In the development of medical readiness, strategic planning is centralizing the planning and decentralizing the execution. However, the medical department must align itself with other governance structures and implement specific adaptive strategies to address objectives mandated by higher authority. Current healthcare re-engineering efforts should be extended to include a strategic analysis implementing specific adaptive strategies. Understanding the current operational concepts and adapting appropriate structures and processes will optimize the development of medical readiness and justify resources for the primary military mission.

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Introduction

The Navy Medical Department is currently attempting to optimize delivery of health care services within the Defense Health Program (DHP) budget. The initiative is based on the Military Health Systems' desire to develop comprehensive integrated services through alignment of governance and collaboration. The initiative parallels the health care re-engineering efforts of the TRICARE managed care program in that it takes advantage of the systems approach (Hall, A. D. & Fagan, R. E., 1968). The military health system (MHS) along with the Navy Medical Department is attempting to align wartime medical sizing requirements with peacetime beneficiary care requirements to efficiently meet its mission in the new millennium.

However, a recent U. S. Government Accounting Office (U.S. GAO) Report stated that despite successful Department of Defense (DOD) and service efforts to improve the Military Health System (MHS) management, DOD still lacks a comprehensive tri-service strategy for determining and allocating medical resources (U. S. GAO, 1999).

Recent legislation portrays a peacetime care emphasis. The Balanced Budget Act of 1997 authorized a Medicare subvention demonstration extends TRICARE benefits to those aged 65 and over. Also, the fiscal year 2000 The Federal Employees Health Benefits Program (FEHBP) demonstration, which was also authorized by the 1999 Act, provides an alternative to MHS direct care system and its managed care contractors care for those 65 and over by offering health care coverage that federal civilian employees have. Finally, the concept of "TRICARE for Life" has been institutionalized in the Defense Authorization Act of Fiscal Year 2001. These issues take emphasis away from the preparation for the primary wartime mission and stretch fiscal resources. The size of the DHP budget today could force DOD to consider buy versus make decisions in operational medicine (Potter, B. B., 2000).

Problem Statement

Impeding the development of a tri-service strategy is the military services' long-standing mission differential and traditional independence, i.e. service culture (U. S. GAO, 1999). The services recruit, equip and train personnel according to their evolved service culture and as defined by their service-specific and joint support missions.

The service secretaries are responsible for effective cooperation and coordination between the DOD and the other federal agencies to provide for more effective, efficient, and economical administration and to eliminate duplication (Title 10 United States Code, 2000). That direction is echoed for the Assistant Secretary of Defense, Health Affairs (ASD/HA) who is responsible to coordinate and exchange information with other Office of the Secretary for Defense officials and the heads of DOD components having collateral or related functions.

Additionally, the ASD/HA is charged to use existing facilities and services of the DOD and other Federal and non-Federal Agencies, whenever practicable, to achieve maximum efficiency and economy (DOD Directive Number 5136, 1994). "Historically, the services have had enough resources to maintain separate health care systems, with capabilities overlapping during peacetime. As a result, over the years, formal inter-service management efforts have been limited and, today, remain difficult to achieve" (U. S. GAO, 1999, p. 2).

In the current military health care environment, each service has its own need determination and resource allocation approach. The approach is strongly influenced by the "corporate" culture, which has evolved from the services core mission, i.e. littoral warfare, amphibious warfare, land warfare and air warfare. Each service allocates resources based on prior year budgets, facility size, location, historical workload, readiness and political considerations, which also emphasizes peacetime care (U. S. GAO, 1999).

Strategy development is further impeded by the fact that the services have not determined the cost of MHS' readiness mission or the cost of peacetime care. Without knowing such costs, DOD is cannot fully justify the MHS' size. The peacetime care emphasis during the past decade has directly competed with MHS' basic readiness mission for resources (U. S. GAO, 1999).

A tri-service strategy applied system wide would enable DOD to assess the need for it capabilities by taking into account the resources needed for both readiness and peacetime care (U. S. GAO, 1999). Such a strategy would also provide a systematic basis for justifying budget requests. Alignment of governance structures and standardization among the medical departments is required to achieve the desired level of system efficiency.

DOD has recently begun to address fundamental deficiencies through the MHS Optimization Plan. The MHS leadership has chartered a reengineering coordination team that has established an “optimization” plan addressing the readiness requirements jointly vice three separate medical departments. The plan has been developed as a readiness based resource improvement model to efficiently address current mission requirements. The services have consulted and agreed on a universal readiness resource sizing model (MHS Optimization Plan, 2000).

However, until the service medical departments can adequately define in standard terms the readiness portion of the overall mission, the MHS cannot fully address concerns note in the most recent U.S. GAO reports. Individual services must define and analyze their own missions at the operational level in order to employ appropriate adaptive strategies that support the optimization of the MHS as a whole. Therefore the services should conduct a strategic analysis to develop specific adaptive strategies critical to establishing a strategic advantage in the development of medical readiness (Ginter, P. M., Swayne, L. E. & Duncan, W. J., 1998). This

study seeks to explore the development and employment of those operational strategies that will target a standards-based medical readiness training system and define medical readiness training requirements within the United States Navy Medical Department.

Literature Review

Modern Military Medical Operations. The last decade of the 20th Century has seen a plethora of studies and literature on the subject of the MHS' medical readiness, i.e. ability to adapt to the Post-Cold War Era and its accompanying operational spectrum. Scrutiny has come from sources that include the United States Congress, the Congressional Budget Office, the General Accounting Office, the DOD Inspector General, the DOD Secretariat, the Joint Chiefs of Staff, the Services and various DOD affiliated research groups. The interest has been primarily targeted on the MHS' ability to develop readiness standards and therefore structure forces to resource future medical requirements.

The Post Cold War operational continuum has seen its focus shift from component warfare to “joint” and multinational warfare. The origins of joint warfare occurred as a result of actions dating back to the early 1900s, graphically depicted in figure 1. However, the requirement for coordination of forces became most evident during World War II (National Defense University Armed Forces Staff College, 1997). The joint focus began to evolve in the National Security Act of 1947 and later its amendments, most notably the Goldwater-Nichols Defense Reorganization Act of 1986. The Goldwater-Nichols legislation enacted the transition to the command authority of the combatant commander by establishing operational and support chains of command II (National Defense University Armed Forces Staff College, 1997).

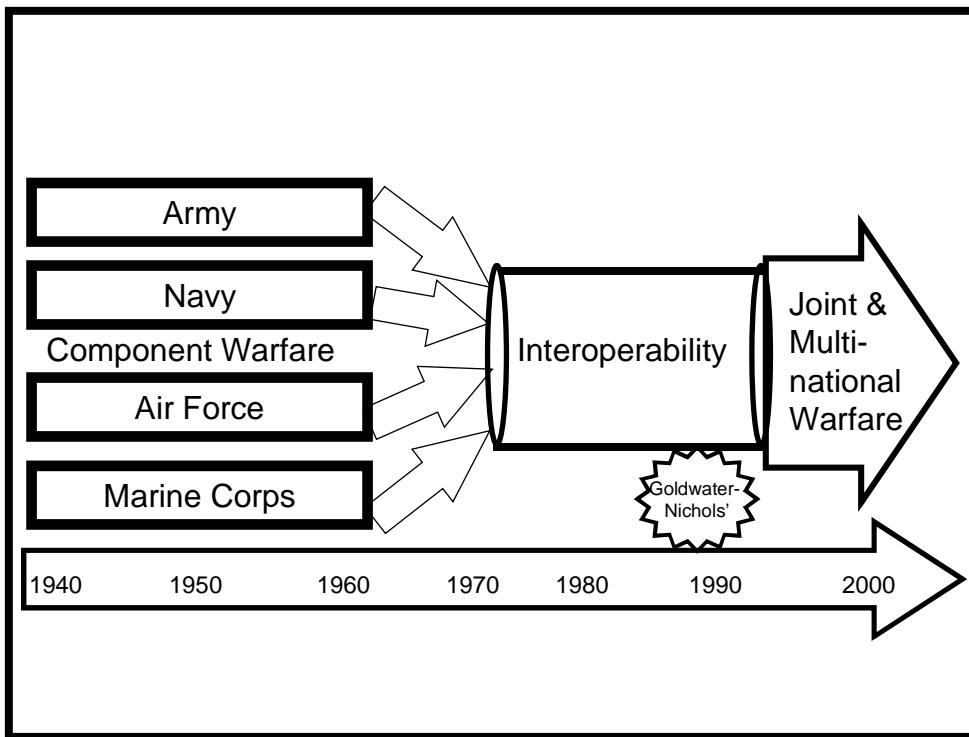


Figure 1. History of Warfare Capability (DOD, Chairman Joint Chiefs of Staff, adapted from figure II-2, p. II-2, 1996).

Title 10 USC further codified the role of the combatant commander and tasked service secretaries to recruit, organize, train and equip the forces assigned to the combatant commander (National Defense University Armed Forces Staff College, 1997). The organization for national security was altered to reflect the combatant command authority of the unified commanders in chief, see figure 2. The combatant commander commonly referred to as the commander in chief (CINC) carries out assigned missions under the direct authority of the National Command Authority. The Chairman and Joint Chiefs of Staff (CJCS) serves in an advisory role and the services in a support role.

Service assignment of personnel to the combatant commander required a structured approach, or “unified action” of the United States Armed Services. This structured approach was accomplished through the development of “joint” philosophies to carry out the national military

strategies (DOD CJCS, 1995). The development of these philosophies is an example of the successful implementation of strategic change that included adaptive strategies that included a decentralized governance model within the DOD. The philosophy has since been translated into “joint doctrine.”

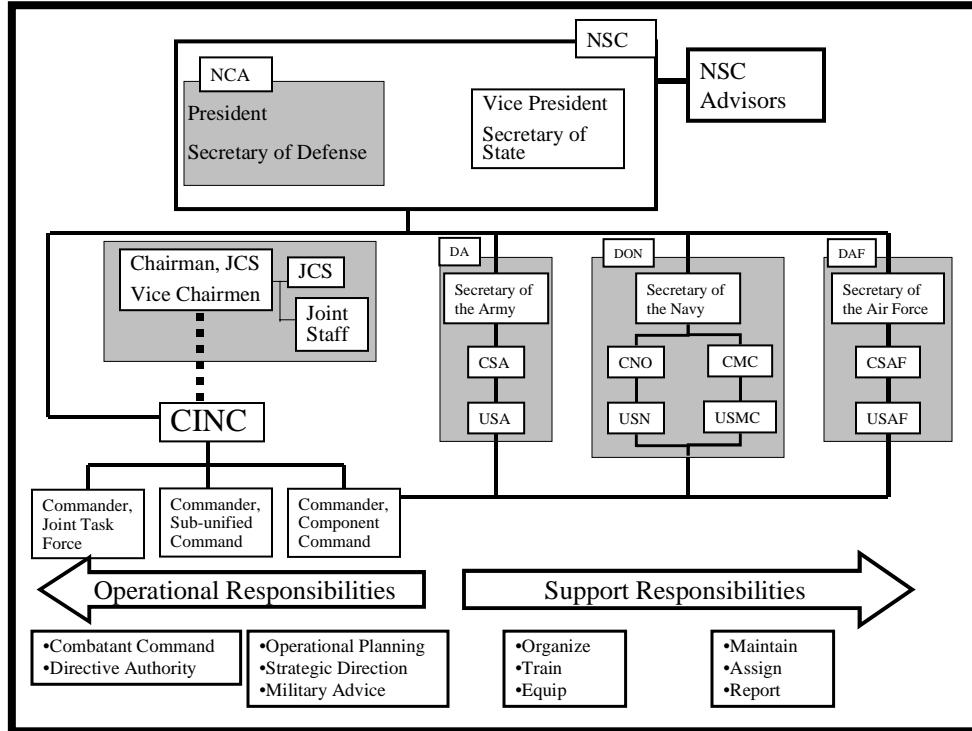


Figure 2. National Command Organization (National Defense University Armed Forces Staff College adapted from figure 2-1 p. 2-3, 1997)

Strategic change is defined as non-routine change or revolutionary change brought about in an organization over time and that deals with technical political and cultural factors that influence an organization or systems' decision making (Tichy, N. M., 1983). The shift to post Cold-War strategy has driven strategic change in the way the United States Armed Forces deal with assigned missions.

“Governance is the activity of an organization that monitors the outside environment, selects the appropriate alternatives and negotiates the implementation of these alternatives with

others inside and outside the organization” (Griffith, 1995 p.178). Within the DOD, the combatant command organization operates in a modified decentralized governance structure in that it centralizes planning and budgeting, while it executes its missions in a decentralized manner. This effectively carries out the unified action of not only the United States Armed Forces, but also the multinational partners who play a role in a wide spectrum of military operations (DOD, CJCS, Joint Publication, Unified Action Armed Forces (UNAAF) JP .01, 1995).

The document that the services used to align themselves under joint doctrine today was Joint Vision 2010, now Joint Vision 2020, which captures the concept of unified action by charging the services and their members to continually look to the future and proactively meet demands on America's Armed Forces. A main focal point throughout this vision is to “accomplish the effects of mass -the necessary concentration of combat power at the decisive time and place - with less need to mass forces physically than in the past” (Joint Vision 2010, 1996). In essence, the “footprint” of the forces assigned to operations will be decreased based on the need for efficiency in a resource-constrained environment. However, this decrease is to be moderated through the application of technology and innovation in developing new operational concepts and methodologies based on sound judgement and the applied modified governance model.

Medical Mission. The MHS’ medical mission is “to provide, and to maintain readiness to provide, medical services and support to members of the Armed Forces during military operations, and to provide medical services and support to members of the Armed Forces, their dependents, and others entitled to DOD medical care” (ASD/HA, 5136.1, 1995, p. 1). Carrying out the Navy Medical Department’s dual mission requires it to govern a complex system of

medical platforms and move towards strategic change in developing its own doctrine to meet today's readiness requirements. The joint philosophy has been effectively promulgated through the "line officer" communities through professional and joint professional military education. This has greatly aided in the various components of the armed forces coming together and effectively training and operating (DOD, CJCS Instruction 1800.01, 1996).

However, the duality of the medical peacetime and contingency/wartime mission creates multiple focal points, i.e. keeping a healthy active duty and beneficiary populations while maintaining a "ready medical operational force", that creates stress points for scarce resources in both the active and reserve components. Additionally, most of the military's medical capability functions either day to day in static military treatment facilities or "part time" in the reserve components (Assistant Secretary of Defense, Health Affairs, 1994). Finally, in the reality that is today's operational continuum, medical forces are often constituted for the joint environment by transitioning to the "operational" chain of command from the "support" chain of command in a static military treatment facility. Therefore the MHS and services require innovation and a "systems approach" in order to meet the needs of today's operational environment.

Medical Operational Issues. The last major regional conflict, Operation Desert Storm identified basic integration problems for all three Services. These problems were noted in reports from the United States General Accounting Office (U.S. GAO, 1992; U.S. GAO, 1993; U.S. GAO, 1993; U.S. GAO, 1995; U.S. GAO, 1996) and an Inspector General of DOD Audit (DOD, Office of the Inspector General, 1996). These reports noted that full medical capability had seemingly not been achieved during Operation Desert Storm. The reports also identified the requirement for military medicine to have an intimate knowledge of a vastly expanded form of medicine in a

hostile environment. This hostile environment required the recognition and reaction to the medical threats across the entire spectrum of potential military operations.

Service medical departments' recruit, equip and train predominantly professional providers. The development of "core common" military medical skills has been secondary and is generally conducted during at the intermediate level, i.e. 04-05 level. Additionally, the medical professional force and its accessioning processes provide medical forces with weaker military skills background than their line counterparts (DOD, Office of the Inspector General Audit Report, 1996).

Professionally assessed military members, i.e. those directly procured into the staff corps, may not be directly exposed to the professional military education because of the technical work they conduct in their specialty and its accompanying continuing educational requirements. However, medical department officers still require an understanding of the capabilities inherent in the DOD subsystems to understand and maintain the strategic advantage American Forces currently enjoy. Across the armed forces strategic advantage is accomplished through component integration and the leveraging of technology to meet the needs of today's operational spectrum (DOD, CJCS, 1996).

The development of Joint Vision 2010 increased expectations for the level of integration among the services and their components emphasizing the need for medical officers to become more intimately aware of the joint philosophies and be able to adapt there current operations to meet mission requirements. The MHS has begun to address this need under Force Health Protection (FHP), the new joint medical philosophy from the Joint Staff's Logistics Directorate, J4, Medical Readiness Division (DOD, CJCS, Joint Logistics, 1999). The philosophy defined the desired capabilities across today's operational continuum enabling service medical components

to refocus efforts on developing the capabilities to provide the following: 1) A Healthy Fit Force; 2) Casualty Prevention; 3) Casualty Care and Management.

These components of the FHP make up a directional strategy that provides maximum protection to service members throughout their military service. The desired outcome is a ready force, fully protected from medical hazards throughout the military operational continuum, i.e. both before and after, not just during operations. FHP is a “total life-cycle” health support system that parallels a concept of focused logistics found in Joint Vision 2010. In this manner, DOD’s most important resource, service members, are to be protected by a synergistic effect of available medical services within the MHS. “FHP takes full advantage of service strengths while also supporting joint standards, doctrine, and operations. This requires maximizing the effectiveness of the services’ medical elements through jointly coordinated, comprehensively planned, and mutually supportive medical operations” (DOD, CJCS, Joint Logistics, 2000).

Medical Readiness Strategic Planning. The MHS has developed a strategic plan to coordinate and comprehensively plan the development medical readiness. The Medical Readiness Strategic Plan (MRSP) uses focus groups to develop the evolving concepts of FHP into operational objectives. The plan was first “officially” issued under the authority of the Assistant Secretary of Defense for Health Affairs (ASD/HA, 1998). The MRSP included the DOD approved definition of overall medical readiness. The definition “encompasses the ability to mobilize, deploy and sustain field medical services; to support any operation requiring military services; to maintain and project the continuum of healthcare resources required to provide for the health of the force; and to operate in conjunction with beneficiary healthcare” (DOD Directive Number5136.1, 1994, p. 1).

The MRSP attempted to “map out” progress required from outside audits, reports and recent operations to meet the challenges of the Post-Cold War operational continuum. The document is organized in 12 major functional areas that are divided into chapters. A theme of maximizing economies of scale and increasing mission capability permeates the MRSP as it puts into motion plans of action assigning primary action offices to meet the objectives. Currently the document is meant to be a linking pin between the directional strategy of FHP and operational objectives to carry out a unified effort.

The functional areas have delineated objectives based on the output of various focus groups pulled together from regional experts within the MHS. Each functional area has a detailed action plan for each objective with assigned primary action office responsible for the objective. The tasks are listed in priority order have due dates and require periodic reports (MRSP, 1998).

Medical readiness training has been designated as one of the 12 functional areas and is mentioned in the objectives of most other areas. The peacetime care orientation noted earlier has been shown to provide an active duty specialty skill mix of personnel and training programs that differ significantly from skills required to support wartime operations and military operations other than war needs (U. S. GAO, 1996). According to the plan, the emphasis on maintaining peacetime health care has impeded the services ability to provide field or “operational” medical readiness training (MRSP, 1998).

Medical Readiness Training. The services’ medical readiness training is developed according to the individual service culture and is reasonably focused on issues specific to the service. However, it has been recommended that the MHS compliance with a CJCS memorandum recommending a combination of training functions and reduction in costs would provide and

opportunity to educate and train for joint and multi-national operations more effectively (MRSP, 1998).

The service secretaries are responsible for effective cooperation and coordination between their own department and the other military departments and agencies of the DOD to provide for more effective, efficient, and economical administration and to eliminate duplication. That direction is echoed for the ASD/HA who is responsible to coordinate and exchange information with other OSD officials and the heads of DOD components having collateral or related functions. Additionally, the office is charged to use existing facilities and services of the DOD and other Federal and non-Federal Agencies, whenever practicable, to achieve maximum efficiency and economy (OSD/HA 5136, 1994).

Governance aspects of coordinating both with the precepts of Joint Vision 2010 and the MRSP have required the same systems approach that has been employed to develop the TRICARE System, i.e. through business process re-engineering (ASD/HA, 2000). Utilizing this approach benchmarks are developed for the “operational” or “health service support”, system. Internal and external benchmarks establish a foundation that can provide the desired outcome of a seamless continuum of medical care.

Internal benchmarking is currently happening to some degree in and among the service medical departments with a variety of readiness re-engineering “efforts” (U.S. Army, 2000; U.S. Navy, 2000; & U.S. Air Force, 2000). Coordination of these efforts through effective governance will help to acquire the best internal business practices within DOD Medical Readiness. The outcomes of these processes can then be juxtaposed against external environmental analysis and benchmarking of accepted industry practices.

The ASD/HA is attempting to implement a more efficient governance structure and centralize planning through the establishment of the Defense Medical Readiness Training and Education Council (DMRTEC) (Assistant Secretary of Defense, Health Affairs, Defense Medical Readiness Training & Education Council Charter, 1997). The MHS, under the guidance of the MRSP, can therefore continue to decentralize the training mission's execution at the service level while maintaining a centralized governance structure to carry out the strategic plan. This should allow service culture and methodologies to remain constant, while supporting the demand for more intensive integration of services within the operation arena.

The chartering of the DMRTEC signaled the ASD/HA's assignment of the responsibility to oversee the evolving medical operational spectrum and effectively respond to the MRSP directive. The responsibilities of the DMRTEC include assessing and consolidating medical readiness requirements established by the combatant commanders and the services. The council is also to provide oversight of medical readiness training and education policies and, joint training standards including recommending changes to ensure coordination of training programs among the services (Assistant Secretary of Defense, Health Affairs, 1997).

The Medical Executive Skills Program Core Curriculum, also an ASD/HA effort, has begun to provide the structure and basis around Health Affairs for the centralization of education and planning (Assistant Secretary of Defense, Health Affairs, Joint Medical Executive Skills Development Program Core Curriculum, 1998). There are forty competencies defined within ten domains that broadly outline the skill knowledge and ability necessary to command Military Treatment Facilities (MTF) and become lead agents under the TRICARE System.

The first domain within the program is Medical Readiness. The domain provides the following competencies and lists supporting behaviors: 1) Medical Doctrine; 2) Military

Mission; 3) Joint Operations/Exercises; 4) Total Force Management; 5) National Disaster Medical Systems Management (NDMS)/Department of Veterans Affairs Role; 6) Medical Readiness Training; 7) Contingency Planning. The Medical Readiness Domain emphasizes the primary mission of the medical department executive's supporting role to the warfighter.

Purpose

This thesis will conduct a descriptive study of employable strategies to address the issue of developing of standardized medical readiness within the United States Navy. The research presented in this paper will maintain two objectives in addressing the ability to develop medical readiness, i.e. the development of operational and adaptive strategies targeting medical readiness training requirements, employment of those strategies and discussion of how those strategies may impact current training efforts.

The focus of this paper will begin broadly in exploring possible strategies for the MHS, then narrow to address implications for the United States Navy's Bureau of Medicine and Surgery due to the experience of the investigator and access to information. This research will be conducted under assumptions based on both the U.S. GAO Report titled "Defense Health Care: Triservice Strategy Needed to Justify Medical Resources for Readiness and Peacetime Care" and action plans in the Medical Readiness Strategic Plan 2004.

The research assumes that the GAO report's assertion that there is no fully employed Tri-service Strategy in addressing medical readiness among the services (U. S. GAO, 1999) is correct. The research also makes four assumptions based on the objectives found within the chapter on training in the MSRP. First, there is no universally accepted readiness training system among the service medical departments. Second, no validated medical readiness training requirements exist within the Navy. Third, there is no approved medical readiness training

standards, joint training requirements, and resources required. Fourth, redundancies exist throughout medical readiness training and economies of scale can be achieved (MRSP, 1998).

Methods and Procedures

A strategic analysis will be conducted by applying the strategic model in determining the appropriate readiness strategy that will ensure the development of quantifiable medical readiness standards. The analysis will include a situation analysis, strategy formulation, and theoretic strategy implementation and the demonstration of strategic control. The situation analysis will include trend and issue identification developed through a timeline, an external and internal environmental analysis and an assessment of the mission and values of the Navy to the MHS Mission and values.

The comparison of the missions and values to current trends and issues defined in the environmental analysis will lead to the identification of strengths, weaknesses, opportunities and threats. These factors will then be combined in a threat, opportunity, weakness and strength (TOWS) matrix to identify specific directional strategies during strategy formulation.

The recommended strategies will then be used in strategy implementation utilizing the quality improvement technique of functional benchmarking. The benchmarks will then to be used as part of the follow-on operational strategies, which will complete the alignment of the appropriate level of strategy with the desired level of strategic control. Basically, the strategy implementation will result in the development of standardized medical readiness requirements. The standardized requirements will be compared to current medical readiness training within the Navy Medical Department to assess the variance from desired MHS capability.

Several operational definitions are required for use in the analysis. Consumers are defined as the congress and the combatant commanders and service providers were defined as

the MHS and the individual service medical departments. The internal environment was operationally defined as the influences that are under the direct cognizance of the ASD/HA. The external environment was operationally defined as those factors outside the ASD/HA cognizance and under the federal government and national command authority control.

Expected Findings and Utility of Results

The strategic model will identify specific operational strategies in dealing with the readiness education and training requirement issue for the United States Navy Medical Department and MHS. Those strategies, theoretically applied, will provide construct validity to goals outlined in the MRSP for training and provide possible resolutions for the findings made by the U. S. GAO Report entitled “Defense Health Care: Tri-Service Strategy Needed to Justify Medical Resources for Readiness and Peacetime Care.” Going further, employment of these adaptive and operational strategies will provide the MHS with operationally defined training requirements and associated measure of readiness. More precise and relevant measures will provide greater strategic control and therefore reliability in the measurement of readiness thus enabling more accurate justification for the assignment of resources within the MHS and Navy Optimization Plans’ sizing models.

Results

Situation Analysis. The application of the strategic model began with the aggregation and cataloging of medical readiness related literature. Cataloging issues allowed an assessment of environmental trends over time. The resulting timeline of issue is provided Appendix A and graphically depicted in Figure 3. The literature review discusses an abundance of literature from multiple sources and associated perspectives on the issue of medical readiness. Figure 3

highlights the primary sources that are exerting influence on the services' development of medical readiness, i.e. the U.S. GAO, the DOD, the ASD/HA and the U. S. Congress (CON).

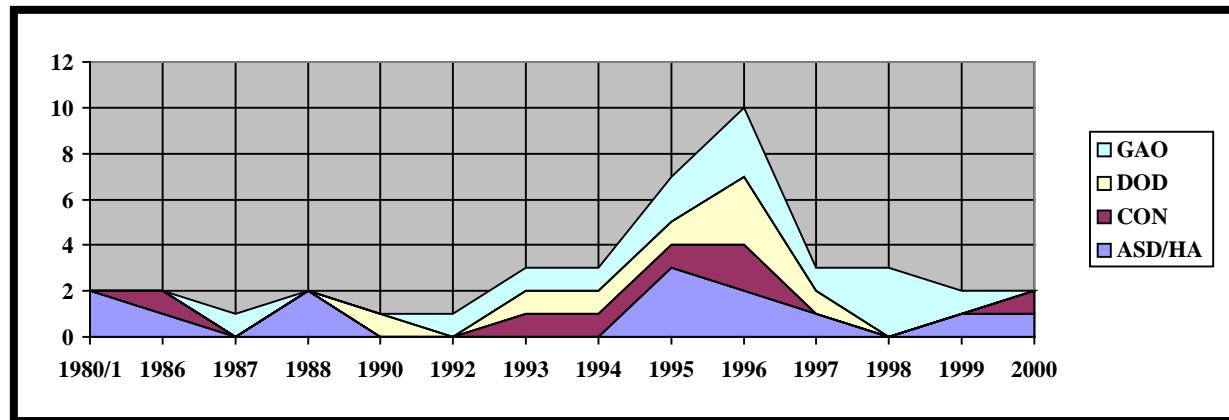


Figure 3. Timeline of Medical Readiness Study

The timeline indicates that the post Cold War and Desert Shield and Storm era reflects a strong focus on the issues surrounding the entire MHS' capability in light of actual operations. The focus of concern peaked around the 1996 time frame and continues at significant levels with more targeted concerns. The primary trend identified among the reports is the appropriate size and mix of capabilities among the service medical departments.

U. S. GAO reports permeate the timeline and have great influence on scrutiny from outside the purview of the ASD/HA. These reports require immediate comment and corrective action. The reports go directly to congress and provide congressional committees the capability to closely monitor the response. The focus of 8 of the reports since 1987 has been the development of a synergistic effect in the military health system's as a cost cutting concern. Across the timeline the U. S. GAO reports specifically identify a lack of systematic processes to develop, measure and maintain its capability and medical readiness.

DOD inspector general audits often reiterate these concerns focusing on educating and training professional officers for the austere environments of the operational continuum. The audits' point out outmoded training and redundant training that result in weak military medical skills.

Congressional concern has centered on the size of DHP and its budgetary usefulness in a downsizing era. The "733 Study" and the resultant follow-on studies pointed out that the MHS exceeded size requirements. While this concern had seemingly been resolved by sustainment requirements, the commissioning of the study by Secretary of Defense in the "National Defense Authorization Act of 2000" continues the focus on MHS size and required capabilities. In the latest study, the Secretary of Defense commissioned the Rand Corporation to identify areas with respect to the DHP, for which joint operations might be increased, including organization and training. The study includes a discussion of the merits and feasibility of establishing a joint training curriculum for the Defense Health Program (National Defense Authorization Act, 2000). The study was originally due October 1, 2000, but was published in the spring of 2001(Hosek, S. 2001). The Health Care Quality Review Panel reviewed the report and in fact recommended the development of a unified medical command to address core concerns (Tomich, N., 2001).

While recent scrutiny has come from current military operations that required a high profile medical presence, concerns about the MHS' capability began much earlier. The post Vietnam conflict era shows the DOD and MHS' concern with the development of "operationally" ready medical forces. Language in Title 10 United States Code (USC) has limited medical officer management within the professional and joint military education models through exemption of staff corps officers to educational and training requirements. This exemption may have negatively impacted the promulgation of joint philosophies in and among

the service medical departments in as timely a manner as their line counter-parts (ASD/HA, 1998 & USC Title 10, 2000).

The ASD/HA has been actively involved in attempts to combat outside concerns since the late 1980s primarily through the MRSP series. The ASD/HA has also sponsored tri-service working groups, organizations and courseware in developing answers to the MHS' medical readiness questions. This can be seen in the historical development of the Combat Casualty Care Course (C4) and its supporting organization the Defense Medical Readiness Institute (DMRTI). The DMRTI is chartered by the DMRTEC to coordinate, evaluate and develop joint medical readiness training with a focus on evolving doctrine and joint operational requirements. The DMRTI is identified as the central coordinating body for medical readiness training. Based on requirements identified by DOD components, DMRTI is to work in conjunction with the military and civilian organizations to enhance readiness programs. DMRTI is conducting ongoing analyses of joint medical readiness training identifying gaps in coverage and redundancies (ASDHA, 1997).

The development of the organizations related to readiness inside and outside the cognizance of the ASD/HA begins to define the environment within which the MHS operates. Graphical expressions of the external and internal environmental influences on the MHS are depicted in appendix b.

Internally, the services are affected by other services, joint organizations, and the ASD/HA itself in the development of "unit" or "service readiness" (CJCS, 1998). The major factors within the internal environment begin with the USC Title 10, which defines the roles and responsibilities of the ASD/HA and services. The Medical Readiness Strategic Plan and Force Health Protection doctrine influence across the support medical command authorities. Finally,

the Military Health Services develop their own doctrine to meet service needs. Internally the interaction among the MHS and individual services provide complex set of influences on the development of medical readiness.

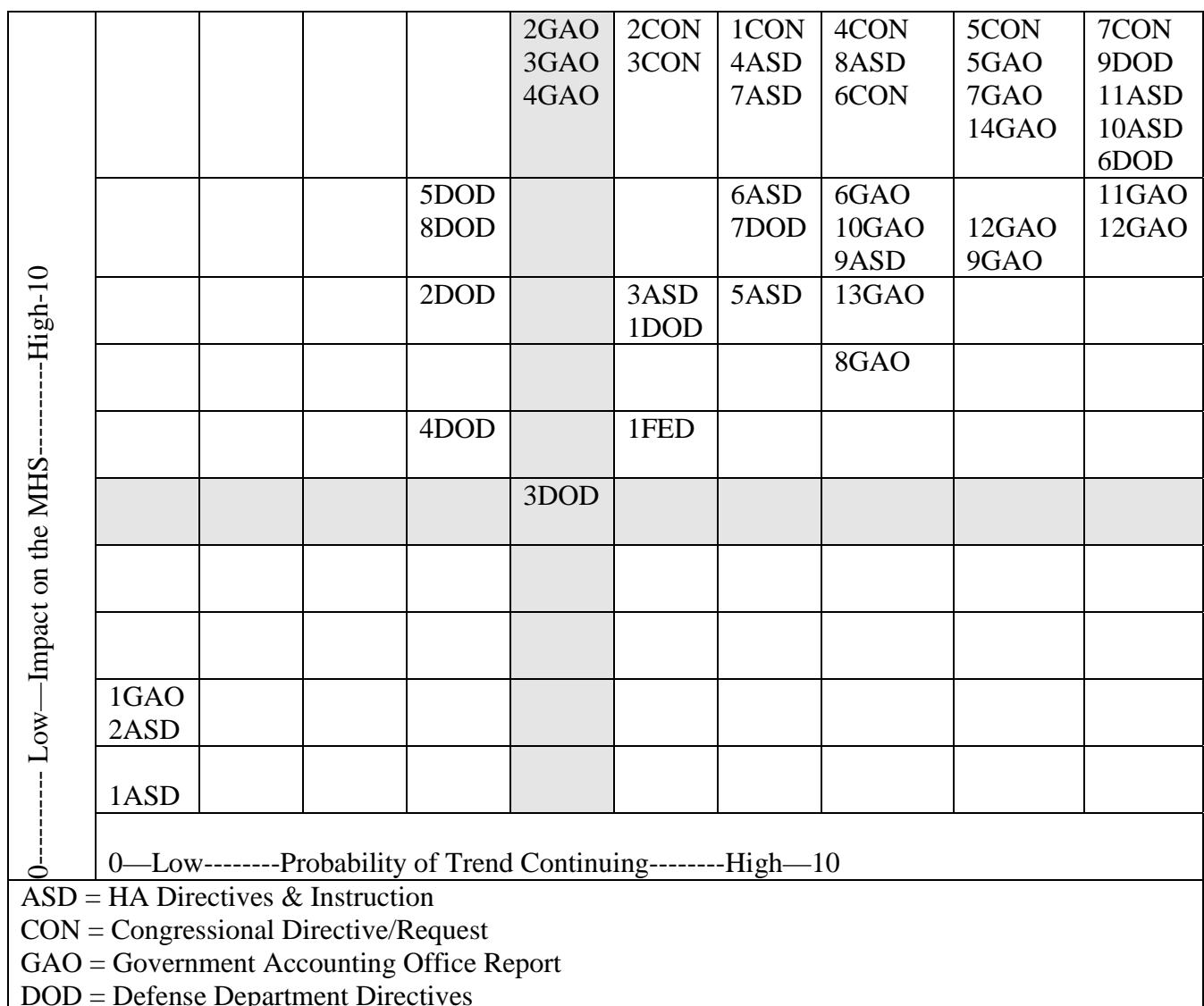
In the external environment, the duality of the medical mission becomes evident. The national command authority seeks to shape, prepare and respond operationally while the federal government attempts to program and budget efficiently in both an operational and “peace time” environment. As discussed in the literature review the peacetime care emphasis is noted in much of the federal guidance. However, the operational commanders emphasize in priority wartime capability and peacetime health care in their respective doctrine.

The environmental factors were consolidated by review of the timeline and were assessed for trend identification and possible extrapolation. Issues were identified by environmental category, designated as an opportunity or threat and then evaluated for probable impact and duration. The evaluation consisted of two separate categorical rankings on a scale from 1 to 10. The categories consisted of the issue’s impact on the MHS and the forecasted duration of the trend or issue. An average ranking was considered to be a 5 in either category. Rankings of issues that were repeated over time were given higher duration rankings in the analysis, i.e. objectives reiterated in revisions of the MRSP.

Correspondingly those issues that have given rise to new legislation or directives resulted in higher impact scores. Finally, the trends and issues were coded for ease in plotting, see appendix a, and plotted using a two dimensional plot. The X-axis consisted of a scale from 1 to 10, which denoted the probability of trend continuing and the Y-axis, which consisted of a scale from 1 to 10, which denoted the impact on the MHS. This plotting tool is used to help focus

strategies on issues and trends that have a high impact on the MHS and a strong probability of continuing using the timeline to identify issues and trends.

Figure 4 displays the resulting diagram of the trends and issues. The diagram shows those U. S. GAO reports, congressional legislation, DOD reports and directives and ASD/HQ reports and directives discussed in review of the timeline. These plots show a generally high impact on the MHS and trends that are every likely to continue. Because a majority of the plots are in the upper right quadrant of the diagram, the issues and trends identified require significant attention in strategy formulation (Ginter, P. M., Et al., 1998).



ASD = HA Directives & Instruction

ASD = Air Directive & Instruction
CON = Congressional Directive/Request

CON = Congressional Directive/Request
GAO = Government Accounting Office Report

DOD = Defense Department Directives

Figure 4 Environmental Trends and Issues Plot

The mission vision and values of an organization are also considered part of the situation analysis because they rely on and influence the environmental analysis. Using these statements will provide the broadest direction for the MHS and can be referred to as the directional strategies. (Ginter, P. M. Et. Al., 1998). The mission vision and values of the MHS are contained in appendix c, i.e. the MHS Strategic Plan, and provide broad directional strategies for both war and peacetime missions. Under the goal of readiness the strategic plan states that the MHS' greatest strength and opportunity will be to "utilize joint operations and reserve" support (ASD/HA, 1999).

The publishing of the FHP and its goals and the latest version of MRSP specify the directional strategies with regard to readiness and list the operational objectives in support of those strategies. The Navy Medical Department's mission and vision statements reflect the support of deployment readiness of the uniformed services through the promoting, protecting and maintaining the health of its patient population and to develop superior readiness through excellence in health services (BUMED, 2001). The department's strategic plan goes on to note that it will optimize readiness in support of the FHP strategy by training to requirements. The MHS, therefore, is poised philosophically to take advantage of the appropriate adaptive operational strategies in the development of readiness today. Therefore, this combined input from the situation analysis could now be used as the framework from which to formulate adaptive operational strategies in the next stage of the strategic model.

Strategy Formulation. The completed situational analysis enables the listing of threats, opportunities, weaknesses and strengths (TOWS) in a diagram, see figure 5. The input to the diagram was analyzed using a TOWS matrix see appendix e. The TOWS matrix indicates four

strategic conditions that an organization can encounter and provides alternatives strategies that can be pursued. The alternatives are realized by the matching an organization's strengths with external opportunities, strengths with threats, weaknesses with opportunities and weaknesses with threats (Ginter, P.M. et. al., 1998).

External Threats	Internal Strengths
Privatization	Centralized Governance
FEHBP	Force Health Protection
Older GAO Reports	MRSP
Rand Corporation Study	Joint Medical Executive Skills
ADRs	Curriculum
TRICARE for Life	MHS Optimization Plan
	Some PME Available
External Opportunities	Internal Weaknesses
Joint Readiness System	Tri-service Strategy Needed
Joint Training System	No Educational Framework
Current GAO Report	No systematic approach
DOD IG Reports	No validated requirements
	No standards developed

Figure 5 Readiness strengths, weaknesses, opportunity and threats

The approach is to look at the organizations current performance, i.e. strengths and weaknesses and factors in the external environment, i.e. opportunities and threats that might affect the organization's future. Once the attributes for each section have been identified, it is possible to determine a point of balance. Eventually the point of balance between strengths versus weaknesses and opportunities versus threats is struck resulting in the optimal strategy to pursue. By building on strengths and taking opportunities organizations can eliminate or reduce threats and weaknesses (Steiner, G. A., 1979).

External threats ranged from a continued emphasis on peacetime care through the extension of benefits in "TRICARE for Life" legislation and inspection and audit reports suggestions left incomplete, to the partial or complete privatization of the MHS' operational

mission. The threats can be leveraged when aligning the internal strengths of a centralized governance structure and the directional strategies contained in the FHP doctrine with the external opportunities of using the joint professional military education and readiness systems.

The internal weaknesses range from no “systems approach” to no validated education and training requirements. Employing the strengths of the already defined MSRP objectives and taking advantage of the opportunities of the MHS Optimization Plan and in guidance from the U.S. GAO and inspector general reports, the MHS and services can eliminate these weaknesses. This can be accomplished through the use of the appropriate adaptive strategy.

The recurring theme of not being able to identify and measure medical readiness requirements results in a matrix weighted in the internal fix it quadrant. This was due to the fact that internal weaknesses have not been resolved through current operational strategies. The lack of systematic and standardized readiness processes renders the MHS unable to fully take advantage internal strengths and external opportunities. The external threats of outside review and replacement are not mitigated by the internal strengths because of the generalized weaknesses of a not fully employed governance structure or systematic approach to the development of readiness.

The internal fix it quadrant suggests the adaptive strategies of contraction and stabilization and then possible expansion. These strategies include retrenchment, enhancement, market development, product development, vertical integration and related diversification (Ginter, P.M. Et. Al., 1998). In essence, the results indicate that the organization should look at a combination of strategies where current operations are stabilized by accomplishing critical tasks, then improving on the efficiency of those operations and finally, then expanding product where possible.

Retrenchment strategy is a response to declining profitability brought on by increasing costs. While the market is still viable, the costs of providing products and services are rising as a percentage of revenue, i.e. a decrease in profitability. Therefore, an organizational response involves a redefinition of the target market; selective cost elimination and asset reduction. The elimination of services that are redundant or superfluous is central to retrenchment. Additionally, services that were added to product lines to round out product lines many have added more cost than benefit to the organization (Ginter, P.M. et. Al., 1998).

The MHS budget requests over the last 3 years have been insufficient to cover their costs and required supplemental appropriations (U.S. GAO, 1999). To develop the basis for costing, the specific critical tasks that comprise medical readiness must be assigned. These tasks include the ability to deploy, training for the specific mission, and the rotation and sustainment active duty medical personnel. “Not having done this, DOD and the services continue operating their health systems not knowing what percentage of their total costs are for readiness needs and what percentage are for non-readiness, peacetime care and little basis for deciding whether to make or buy peacetime care services” (U.S. GAO, 1999).

Looking at today’s readiness mission, it calls for a smaller, more mobile medical force then during the Cold War (DOD CJCS Joint Logistics, 2000). The services have responded with reengineering efforts on their operational platforms. Each of the medical departments deployable medical systems (DEPMEDS) has been reconfigured to smaller and more mobile sizes. However, overall assets, end strengths and capability are awaiting the results of the consolidated sizing model from the MHS Optimization Plan (U.S. Army, 2000; U. S. Navy, 2000; & U.S. Air Force, 2000). Additionally, the reconfiguration of DEPMEDS by the services has been

independent. Therefore, bed capability, facility configuration and manning requirements vary among the services.

The MHS' primary mission and the justification for having active duty medical providers, is wartime medical readiness. However, in the past 20 years, budget pressures and a growing retiree population's demands, DOD has increasingly focused on providing peacetime care. DOD's non-active-duty population has continued to increase since the Cold War. During the 1990s the numbers of retirees and their dependents grew to more than half of the total beneficiary population, see figure 6. The trend, developed over the past 40 years is expected to continue (U.S. GAO, 1999).

Therefore it is ever more critical for the MHS to pursue a strategy of retrenchment to address the issue of what capabilities are needed for war and what will sustain those capabilities while meeting the peacetime mission needs. After the Gulf War, the U. S. GAO and DOD Inspector General reports questioned DOD's ability to meet wartime medical needs as discussed in the literature review. Large numbers of medical personnel were not deployable due to their unacceptable physical conditions, lack of required skills, mismatched medical specialties, and a "pervasive" lack of wartime readiness training (U.S. GAO, 1999).

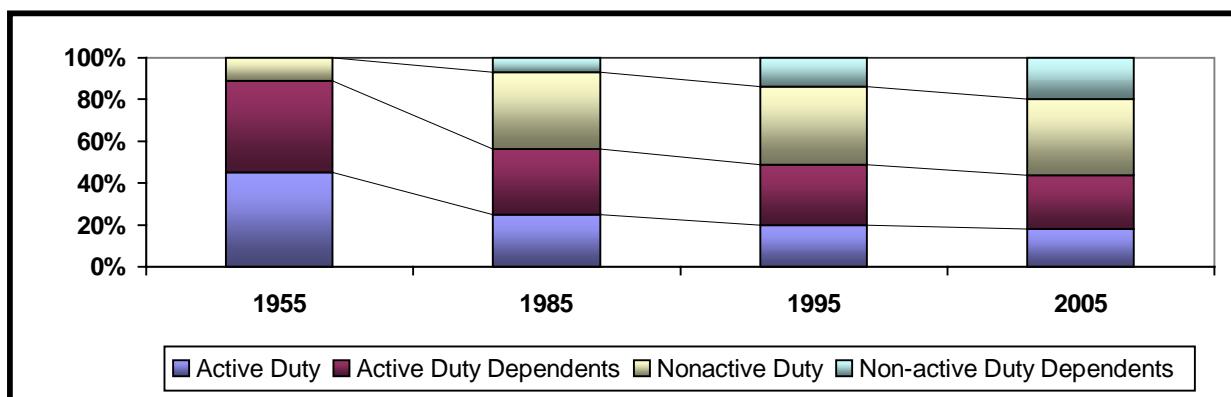


Figure 6 Percentage and category of DHP Beneficiaries (U.S. GAO, 1999)

The FHP Doctrine has conceptualized retrenchment at a strategic level. However the construct has yet to be “operationalized” through the reengineering and optimization processes. Within the MHS the services derive readiness goals to a successful degree basing efforts on the individual services needs and CINC needs, i.e. FHP doctrine. As admitted in the MRSP and documented in multiple GAO reports a “systems approach and tri-service strategy is still lacking” (ASD/HA, 1998). The perceived gap between what the end-users want and what the service provider’s have yet to deliver, is operational objectives that can measure progress toward those goals (U.S. GAO, 1999).

The enhancement strategy is appropriate when management believes the organization is progressing towards its goals but needs to “do things better” (Ginter, P.M. Et. Al., 1998). The purpose of the MRSP is to provide DOD with an integrated, coordinated and synchronized plan for achieving and sustaining medical readiness (ASD/HA, 1998). Typically, this suggests that the MHS continue to utilize advanced quality improvement techniques to implement the appropriate adaptive strategies at the operational level.

The MHS has utilized focus groups in the defining critical areas of medical readiness strategy in the MRSP. However, a limitation of this technique has been that it was difficult to summarize (Mears, P. 1995 & ASD/HA, 1998) findings in an action report that is less complex than the interdependent action plans found in the MRSP 2004.

An alternative technique that provides breakthrough approaches and tools needed to both retrench and enhance readiness processes is the benchmarking technique. Benchmarking looks around and outside the organization to demonstrate how others have solved similar problems (Mears, P. 1995). Finding, studying and implementing best practices provides the greatest opportunity for gaining a strategic, operational, and financial advantage (American Productivity

& Quality Center, 2001). Thus, the MHS and services can utilize benchmarking to mitigate its weaknesses and threats by taking full advantage of its strengths and opportunities in a benchmarked readiness model.

Of the various types of benchmarking internal and functional benchmarking provide models with established operational definitions of the readiness processes internal and external to the MHS. The readiness processes within the MHS provide internal benchmarks, i.e. between the services. Functional benchmarking outside MHS provides the “joint” processes.

The FHP doctrine provides the operational definitions for internal medical readiness benchmarking. The ASD/HA has established a governance structure to implement readiness training benchmarking as noted earlier with the DMRTEC & DMRTI. However, a tri-service readiness system is not currently in place (ASD/HA, 1998). Looking outside the MHS across DOD, functional benchmarking identifies the joint education, training and readiness systems that develop strategic readiness for the armed forces of the United States. It is from these systems that the DOD has retrenched and enhanced its required operational capabilities in the Post-Cold War Era. It stands to reason that MHS could use these systems as a benchmark to implement its own readiness system.

The professional and joint military education models and the joint training system provide the basis for developing readiness among line commands. The Professional Military Education System (PME) and Joint Professional Military Education System (JPME) prepare military officers’ by developing the critical thinking and cognitive ability necessary to enhance warfare capability. According to the DOD, this is a critical function in today’s dynamic operational environment (DOD CJCS Manual 3500, 1996 & DOD, CJCS Instruction 1800.01, 1996). Appendix f provides an overview of the PME and JPME curriculum emphasis.

Utilization of these two systems within the MHS establishes a formalized systems approach from which military medicine can develop an optimum “operational” benchmark to refine objectives and meet strategic goals of the military health system.

The established knowledge and skills can then be used to adapt required warfare capabilities based on today’s national military strategy. These capabilities are developed and maintained through training requirements and measured according to developed standards. The DOD accomplishes this “sustainment” through the joint training system (JTS).

The JTS, see figure 7, consists primarily of a Shewart Cycle, i.e. plan, do, check, and act cycle, in which missions are analyzed to produce capability requirements along with standards and their associated conditions that will ensure mission success. A plan is then developed to ensure training to those requirements. The plan is executed and then assessed for input back into requirement development (DOD, CJCS, 1996).

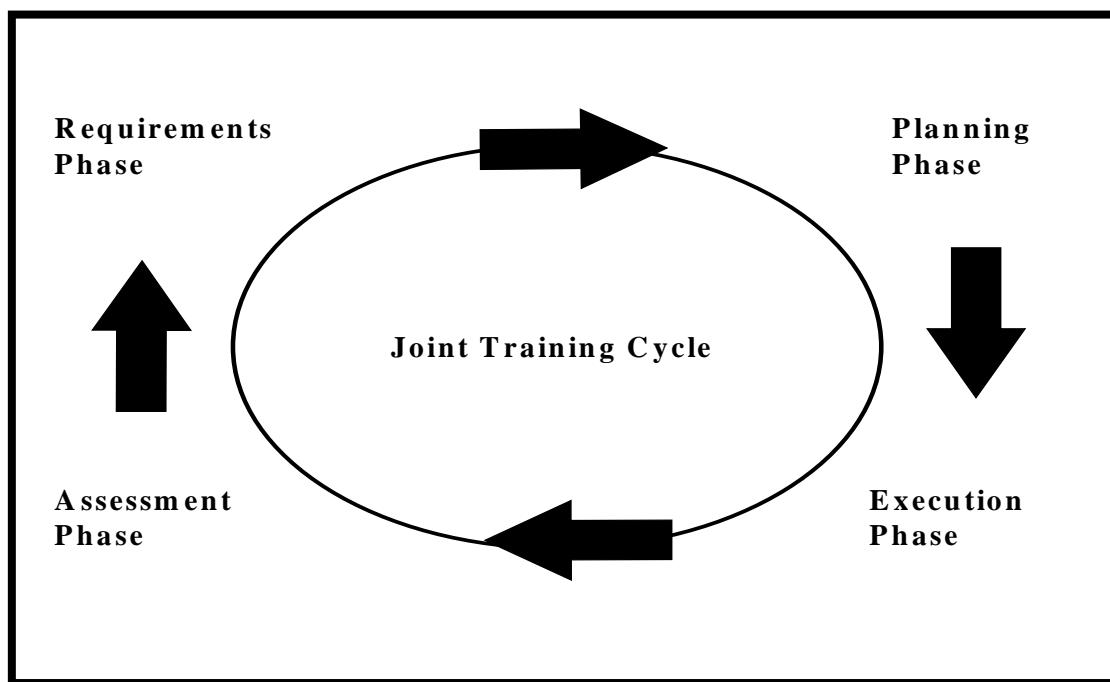


Figure 7. The Joint Training System

The Chairman of the Joints Chiefs of Staff assesses readiness by the ability to execute the national military strategy or war-fighting capability. Figure 8 depicts the interaction within the joint system in a triad. Readiness can be described at three levels strategic, joint, and service readiness. Therefore, the development of medical readiness must account for the strategic, joint, and service medical readiness.

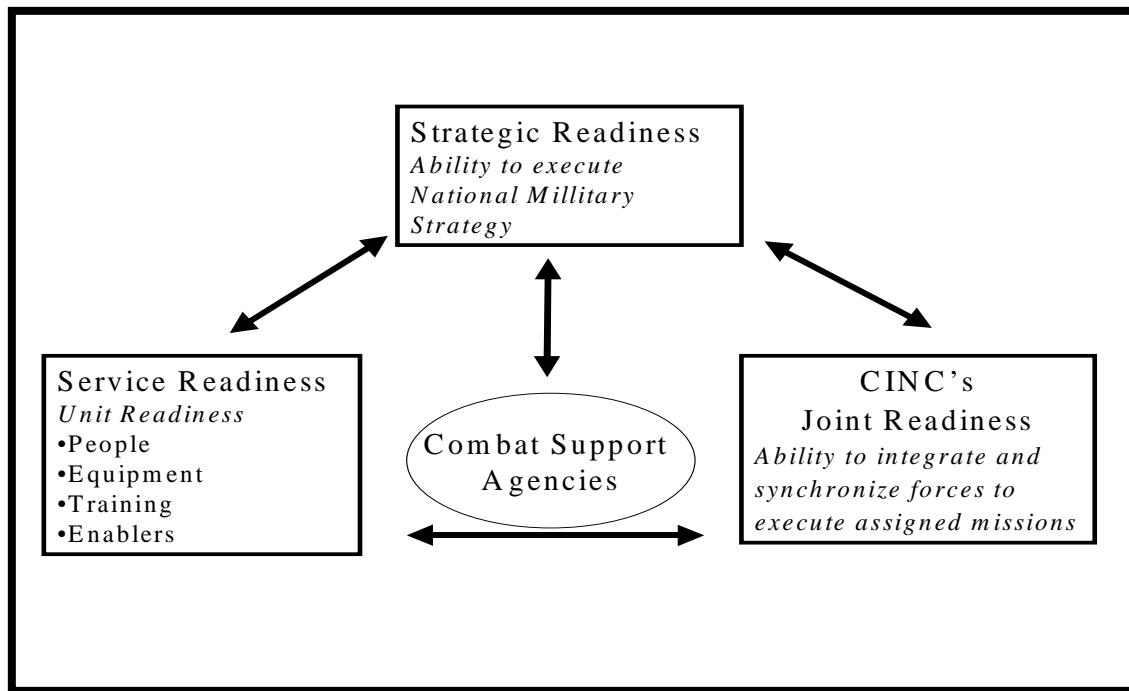


Figure 8 Chairman's Readiness Assessment System

Strategic readiness is the level at which the Nation Security Strategy determines national security objectives. The FHP doctrine as an adjunct to JV2010 provides the directional strategy and the MRSP the objectives for the MHS. Readiness at the operational level for the medical components is defined in the transition form support responsibilities to the operational responsibilities.

Joint readiness is defined as the Combatant Commander's ability to integrate and synchronize combat and support forces to execute his assigned missions. Therefore, the

establishment of joint medical readiness is MHS' ability to provide capable medical components to the Combatant Commanders.

Service readiness is determined by the provision of trained and equipped forces capable of executing assigned missions within the operational continuum, i.e. the ability of each unit to deliver the outputs for which it was designed (DOD, CJCS Guide 3401A, 1997). Here the duality of the medical mission focuses strategies on the development of readiness on training. In the Navy, medical operational platforms, i.e. fleet hospitals, casualty treatment and receiving ships and hospital ships, are maintained as commands separate from military treatment facilities with designated resources and are not fully manned.

Navy Medical department operational platforms are augmented by personnel from military treatment facilities (MTF) as they become assigned to missions (Department of the Navy Bureau of Medicine and Surgery, 2000). Both the Army and Air Force augment medical platforms in similar fashion although not to the same extent or manner (U.S. Army, 2000; U.S. Air Force, 2000). Therefore, the medical departments, in strategy development, must address the capability to adequately train and measure in standard terms the readiness of members who are working full time in a peacetime role.

A full assessment of readiness accounts for the interplay between the three primary levels of the readiness. The services and the MHS governance are currently attempting to develop alignment with both joint and service readiness based on the FHP philosophy. However, according to the analysis at this point, the MHS has not fully implemented the operational strategy that will adequately align governance of readiness, i.e. through training and education structures, that will provide the true level of readiness in quantifiable terms (ASD/HA, 1998; U.S. GAO, 1999). Focusing the combination strategies of retrenchment and enhancement on training

requires the adaptation of the benchmarks provided in the joint educational, training and readiness systems. The benchmarks can aid in forcing existing structures into alignment across levels of operations and command establishing strategic control as shown in figure 9.

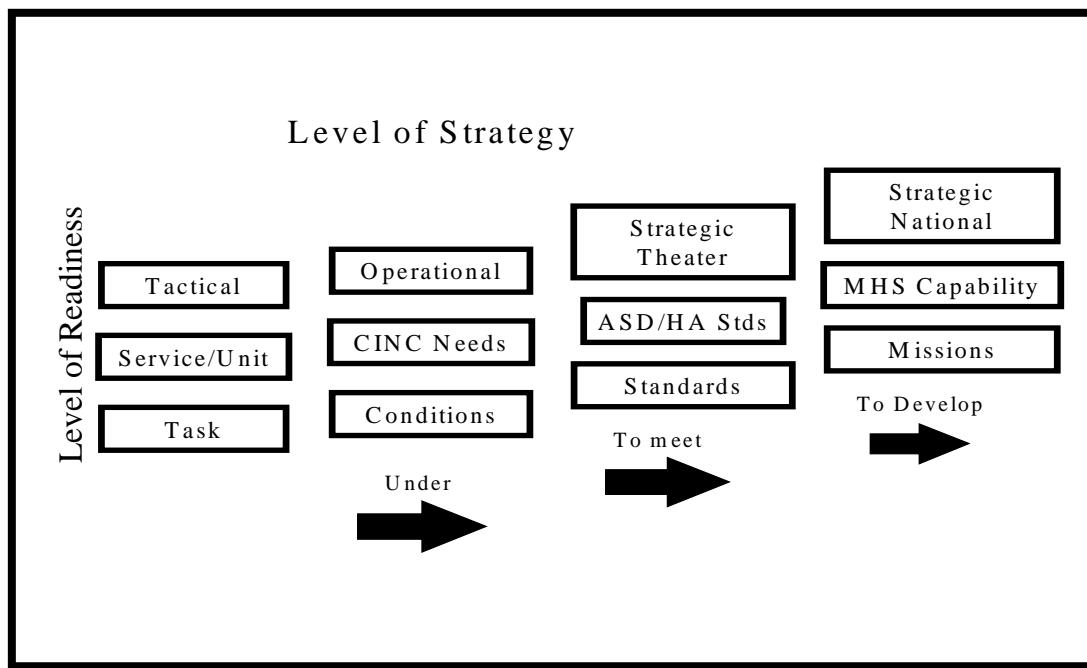


Figure 9. Readiness Alignment

Strategy Implementation. The adaptation of the PME, JPME and JTS structures will require only minor modification to those found in doctrine. The introduction of the joint philosophy in conjunction with service specific needs is already a centerpiece of the current PME/JPME template (Chilcoat, 1999).

The “Gap Analysis” being conducted by the DMRTI had originally identified a lack of joint orientation in the basic readiness courseware available to medical department personnel (DMRTI, 2001). For instance, professionals assessed into the service medical departments are not always provided the requisite war fighting philosophies during indoctrination or even so in the same manner. While this is dependent upon the service education and training culture, it does not support standardization and coordination.

According to the PME and JPME models members should have an introduction to their respective service readiness and have knowledge of joint force structures, capabilities, and operations at the pre-commissioning and officer training school level. Once at the primary levels, i.e. 01-03, members should be exposed to the fundamental concepts of JTF organization, command and control, employment, and operations (DOD CJCS Instruction 1800.01, 1996). However, the Navy's Officer Indoctrination School at Newport Rhode Island offers no curriculum directly supporting naval or joint medical operations and very little readiness training (CNET, 2001). Other medical officer training programs like the U. S. Army Officer Basic Course and Officer Advanced Course held at Fort Sam Houston also offer little or no curriculum devoted to joint doctrine (AMEDD C & S, 2000).

Applying the FHP doctrine and Joint Medical Executive Skills Curriculum can provide the basis for the possible adaptation of the PME & JPME curriculum as shown in figure 10. The curriculum is based on an incremental career development of both service and joint medical operational guidance and philosophy. It develops members in a manner consistent with required skills and cognitive abilities across levels of operation and command. As noted earlier, there is need for strategic change like that seen in the shift from component warfare to joint warfare. The career continuum allows current strategies to influence service culture at early stages breaking down resistance to strategic change.

As mentioned in the literature review, the Joint Medical Executive Skills Program Core Curriculum (ASD/HA, 1998) provides the basis around which the ASD/HA can centralize planning for readiness education. This centralization also lays the groundwork for a “standards based” medical educational and training continuum for the MHS. In this manner, medical

personnel assessed into any of the three services will receive the requisite knowledge and skills across a career continuum to function in support of the continually evolving mission.

MEDICAL OFFICER READINESS EDUCATIONAL FRAMEWORK				
GRADE	0-1/ 0-2	0-3/0-4	0-5/0-6	0-7/ 0-8/ 0-9/0-10
LEVEL OF READINESS EDUCATION	PRIMARY	INTERMEDIATE	SENIOR	FLAG
EDUCATIONAL INSTITUTIONS & COURSES	Officer Indoctrination MED 56 Courseware -NOMI -FMSS -DMRTI	NOMI Courseware -AFMIC -FMSS -NSHS -DMRTI NPG School Armed Forces Staff College	NPG School Marine Corps War College Industrial College of the Armed Forces Armed Forces Staff College	Capstone Seminars/ Courses
LEVEL OF WAR EMPHASIZED	CONCEPTUAL AWARENESS OF ALL LEVELS	Tactical	Operational	Strategic
FOCUS OF MEDICAL READINESS EDUCATION	Introduction to Service Mission & Values Service Medical -Operations -Staff Skills -Leadership	Platform Operations Casualty Care & Management Preventive Medicine Health Promotion Medical Evacuation Communications NBC ---Patient Mgmt ---Force Protection Medical Intelligence Technology Integration	Apply Medical Doctrine Defense Planning Guidance Developing Medical theater strategies Evaluation of Force Health Protection & Sustainment	Theater- Level Unified, Joint & Combined Operations
JOINT MEDICAL EMPHASIS	Capabilities of the MHS Joint Doctrine Intro: JCS Origins & Organizations Force Health Protection	Joint Task Force Org. Intro to Joint Medical Executive Skills: -Medical Doctrine -Military Mission -Joint Ops & Exercises -Total Force Mgmt -NDMS Mgmt & VA Role -Medical Readiness Training	MHS Role in support of the National Security & Military Strategies Developing competency within the Joint Medical Executive Curriculum	Integration of NMS & National Policymaking Requirements

Figure 10. The Medical Professional Military Educational Emphasis

Medical Readiness Training and sustainment of skills is also heavily dependent on the service culture. By applying a war-fighting training system, the JTS, to FHP and the service's re-engineering efforts the knowledge and skill base can be sustained and enhanced. A basic premise of the JTS is to plan centrally and execute de-centrally. The MHS has already constructed a plausible governance structure that can take advantage of centralization with the DMRTEC and DMRTI. Within the Navy Medical Department, the centralization of planning has begun with responsibility for the development of readiness training shifting to the expanding Naval Operational Medicine Institute (NOMI). The institute's mission is to provide specialized and

operational medical training for military forces worldwide with a vision of becoming a subject matter expert in operational medical training (Naval Operational Medicine Institute, 2001).

Adapting the JTS creates a medically specific, doctrinally based training system that carries out the MRSP training objectives within the FHP strategy. The Requirements Phase is the first phase of the JTS and for the MHS it will consist of the development of training requirements with associated conditions and standards. In the JTS the phase is based on doctrine, guidance, and current missions and issues identified during assessments of CINC needs. Initially, the benchmark input for the requirement phase will come from the FHP directional goals and MRSP objectives.

At the service level, requirements or mission essential task lists are developed depending on the platform employed and specific mission. The lists define what tasks are most critical to mission accomplishment. In the MHS some trade-off is usually required to ensure that tasks don't compete for the same resources (DOD CJCS Manual 3500.03, 1996). However, aligning the service mission requirements links them to the operational objectives outlined in the MRSP which are in turn linked to the goals outlined in the FHP strategy.

In developing requirements, the Navy Medical Department must meet not only service specific mission requirements but also those of the combatant commands. Developing similar medical capability to the other services does this. Therefore, these requirements can be considered component interoperability tasks. This is the critical difference between service specific and joint force training. Component interoperability tasks align capabilities beyond service specific platform training and support an incremental approach in the joint training system. Figure 11 shows a targeted approach depicting how core service training is built upon and expanded by joint training.

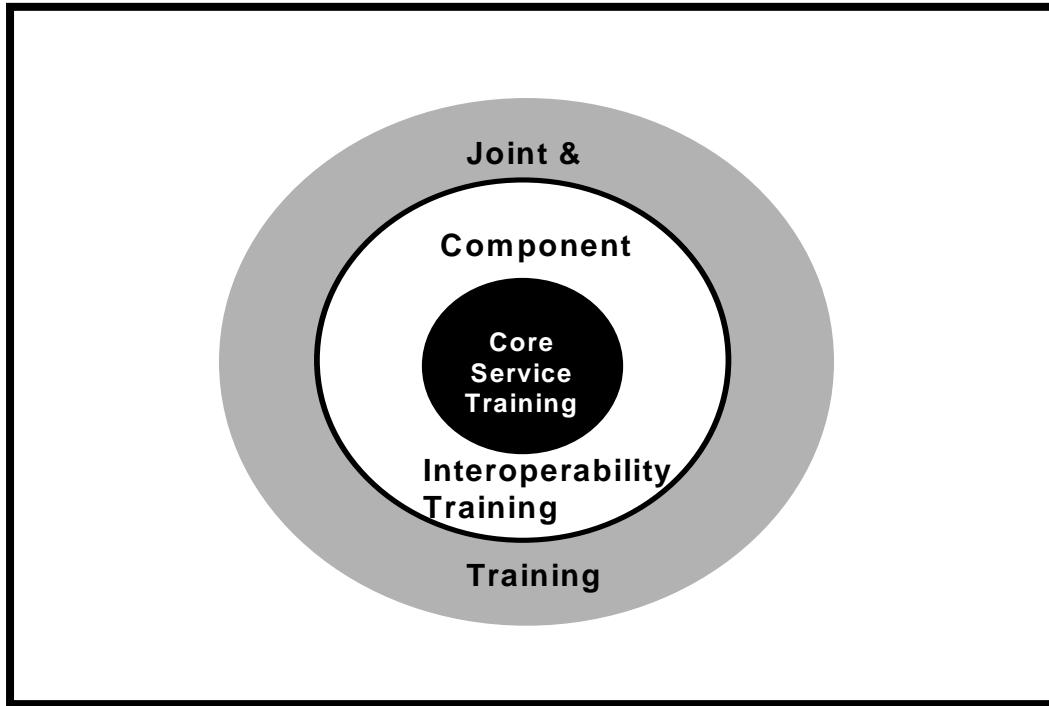


Figure 11. Targeted Readiness Training

In order to align medical capability the input must be expressed in the common, i.e. standards based language of the Universal Joint Task List (UJTL). The UJTL (CJCSM 3500.04, 1996) is a comprehensive hierarchical listing of the tasks that can be performed by a joint military force organized by the three levels of war, i.e. strategic, operational and tactical. It serves as a reference system for component and functional commanders' needs to combatant command missions. The UJTL also provides a basis for describing joint requirements, capabilities, and combat activities across levels of war.

Using the guidance provided in the FHP and MRSP, medical component interoperability tasks can be defined at the strategic, operational and tactical levels of war, an example is provided in figure 12. These required medical component interoperability tasks defined in a common language will enable the MHS to more accurately measure service and joint readiness

within the joint readiness system. Additionally, standardization will allow the efficient consolidation of efforts and optimization of the readiness training system.

Strategic National	Healthy Fit Force	Casualty Prevention	Casualty Care & Management
Strategic Theater	Psychological Health Physical Health Occupational Health	Environmental Hazard Awareness Occupational Hazard Awareness Enemy Force Threat Assessment	First Response Forward Resuscitative Surgery Theater Hospitalization Medical Evacuation Logistical/Blood Support
Operational	Family Support Services Periodic Health Assessments Health Promotion Programs	Health Surveillance Preventive Measures Combat Stress Programs Medical Intelligence Assessment & Communication	Basic Life Support Stabilization Enroute Care Modularized Support
Tactical	Employ Health Promotion & Wellness Programs	Employ Counter-measures NBC Medical Capability	Triage Basic Life Support Evacuation

Figure 12. FHP Tasks across levels of war.

An important note to this requirement determination is that requirements must also be viewed in the context of the overall task listing within a given level of operation. This view is based on medical force integrating as subordinate and support commander roles of health service operations. Medical forces or commands much like other component forces, transition from support roles to operational roles. This carries the responsibility of command authority into a different environment requiring military readiness. Figure 13 provides an example of how the tasks can be viewed at the operational level of war (DOD CJCS Manual 3500.03, 1996).

In the Planning Phase of the JTS, services develop training plans based on the established requirements. In this phase, training methods are selected to make best use of available resources, target the appropriate training audience, and assess the audience to establish essential

areas of emphasis, develop objectives, determine the method and finally design training events. This will be a critical phase for the adaptation of military medicine, but one that will alleviate some of the burden of training for the dual peacetime and wartime missions (DOD CJCS Manual 3500.03, 1996).

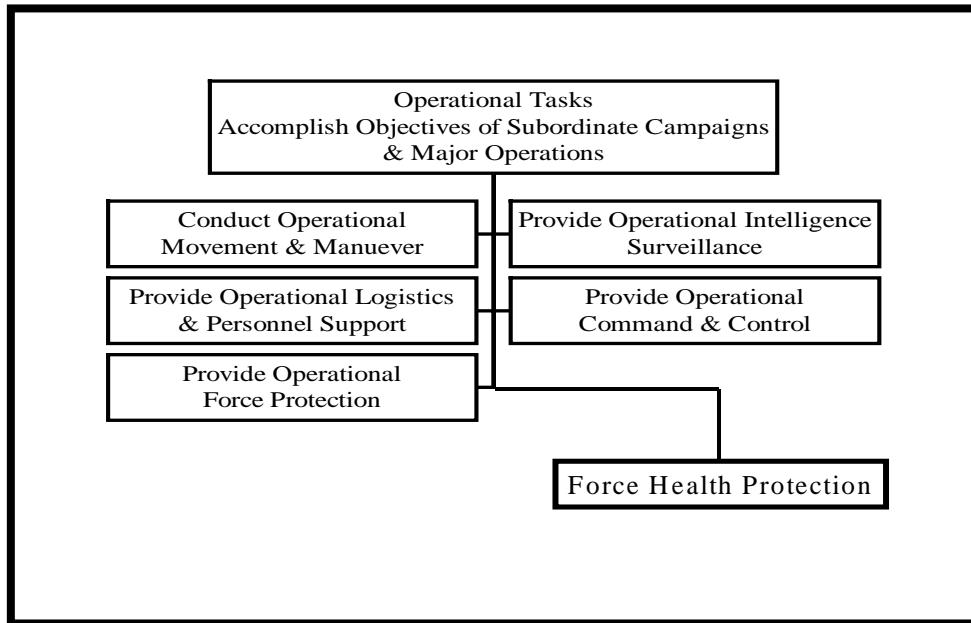


Figure 13. Operational Level Tasks

A critical point in this phase will be the integration of alternate delivery methods, technology assisted training, and advanced distributive learning initiatives mandated by the DOD. The services or components can maintain a heavily influence on the selection of training mediums knowing how capability is best developed within their respective service, i.e. the make-up of the technical, political and cultural factors.

In the JTS, the appropriate training method is selected based on three factors; 1) Level of training proficiency of the training audience; 2) The perishability of training; 3) Time available to train. Ideally, the training plan would outline a building block approach to training in that

each training activity would build on previous training and prepare the forces and/or staff for the next training event.

The decision of the most appropriate medium should be based on two factors; 1) the best way to deliver the content; 2) the most cost-effective in terms of both time and money.

Specifically, the need for “just enough” and “just in time” training can be addressed at this point through targeting of training to the most appropriate audience and command level. This would empower commanders up and down the chain to utilize training tools locally and send the right personnel to right place to accomplish “value added”, i.e. or more meaningful training.

Additionally, this phase allows the programming and budgeting to more accurately reflect a training and exercise strategy that is better aligned with the National Military Strategy and a stable process for applying service resources.

The Execution Phase contains an “event life cycle” that identifies ways to effectively meet training audience needs by stepping the learning objectives, derived through the planning phase, through the training event and then critiquing the event upon completion. The execution phase produces a formalized, executable event plan with specific resource requirements and learning objectives that successfully adapt to and execute training events (CJCSM 3500.03, 1996).

Strategic Control. The Assessment Phase is the final phase of the training system and provides a baseline for strategic control is the study of applied of the parameters, i.e. measures and criteria to readiness training and education. The focus of the assessment phase is on the identification of trends and issues from the execution of training and education. The trends and issues identified serve to impact future training requirements, planning and execution by focusing on shortcomings or deficiencies (DOD CJCS Manual 3500.03, 1996).

Measures and criteria are also used in understanding and integrating operations to a developed standard. A measure is directly related to a task such as the speed in accomplishing a task. A criterion defines acceptable levels of performance and is often expressed a minimum acceptable level (DOD CJCS, 1995). The parameters along with standards determined after the training cycle has had a chance to proceed will provide a way to measure the readiness mission both in the development of “ready” medical forces and the carrying out of actual missions.

Three main assessments types of assessments are made in the JTS and reflect the capability to perform assigned missions acting as tools for commanders to complete the training cycle. The assessments include proficiency, capability and status of force type of reviews. The assessments can be expanded to review the education aspects as well for the MHS and services.

Proficiency assessments are carried out at the unit level and analyze current service and joint competencies among medical personnel. The navy medical department documents this through the medical personnel augmentation system (MPAS) module of the standard personnel management system (SPMS). However, the MPAS documents and reports on training based on completed courses as opposed to specific measure and criterion. According to the Medical Augmentation Program (MAP) Instruction the specific skills are not required only a matrix of courses is listed for each platform. This limits the ability of the navy to accurately measure readiness development. Additionally, the skills are not operationally defined in measures that lend themselves to standardization.

The second, type of assessment is the capability assessment and is carried out at the unit level. In this assessment medical readiness training issues are identified across command echelons as shortcomings in doctrine, organization, training, education and materiel. The Navy Medical Department has instituted an operational readiness examination for its fleet hospital

platforms. Generally, these type of assessments happen as part of lessons learned and after action reports. The navy lessons learned system supports this type of assessment; however, no medical repository has been standardized or promulgated.

The third assessment compiles earlier assessments and identifies trends and issues across the department and or MHS and can be used as general indicators of overall readiness. This assessment occurs at the Joint Staff or in the MHS' case the ASD/HA's level. Readiness related issues are relayed up and down the chain of command for remedial action and resolution in the form of the strategic plan objectives. As mentioned previously, focus groups are used by ASD/HA to refine and develop objectives within the MRSP.

Discussion

Historical Perspective. The ASD/HA Office, as a result of congressional concern established the Combat Casualty Care Course. The course was designed by a task force of regional medical readiness experts and designed to provide wartime medical readiness training that was not offered at the time (Wehrly, D. J., 1995). It was the first attempt at congealing the service medical departments' capability and interoperability in light of lessons learned during the Vietnam War. In retrospect this development can be viewed as a watershed event in that resources were directed at "joint" medical readiness training because it attempted to analyze what CINC surgeons needed to support the Combatant Commander.

The advent of the Goldwater-Nichols Act in 1986 seemed to re-enforced development of the C4 curriculum in that it required "joint force" emphasis in professional military education (PME) and training. The task force had become a subordinate command structure under the Army Medical Department Center and School, the Joint Medical Readiness Training Center (JMRTC). JMRTC had expanded its courseware and was offering field training for both junior

and senior officers. However, a critical point within USC Title 10, staff corps officers could be exempted from military education requirements based on their technical professional skills. This lead to medical readiness education and training development independent of the line community efforts in the late 1980s and early 1990s (U.S. GAO, 1999).

The independent development maintained the decentralized governance structures that inhibit strategic change. Three critical factors that influence strategic change depending on their relative strengths and weaknesses are technical, political and cultural influences (Tichy N., 1983). The three service medical departments are influenced by these factors based on separate missions and thus have developed distinct corporate cultures, political hierarchies and technical proficiencies. This difference is reflected in the way medical professionals are assessed into the three service medical departments.

While most will acknowledge a governance structure existed through the spirit of cooperation among the services prior to Desert Shield/Storm, no real strategy or official directives actually existed (UASD/HA, 1998). It was not until 1998 that the governance structure of the ASD/HA was officially modified to include organizations whose purpose was to support the development of medical force interoperability and integration. The establishment of the Defense Medical Readiness Training and Education Council (DMRTEC) (ASD/HA, 1997).

The chartering of the DMRTEC signaled the ASD/HA's assignment of the responsibility to decentralize the training mission's execution at the service level while centralizing the planning and programming at the Secretary's level. In a much smaller case this can be considered a parallel to the "regionalization" of tri-service healthcare under the umbrella of the TRICARE Program. In effect, the coordination of the doctrine and guidance can now be accomplished effectively addressing service cultural factors.

Medical Readiness Education and Training Reality. In the reality that is today's operational continuum, medical forces are often constituted for the joint environment by transitioning to the "operational" chain of command from the "support" chain of command in a static military treatment facility. Alluded to earlier, training for this transition is, for the vast majority, executed as an additional responsibility to day to day operations.

As an example, Naval Medical Center Portsmouth (NMCP) supports 11 operational platforms with 1500 billet requirements among its military personnel. This is over half of its military manning, i.e. 2764. NMCP experienced the support requirements for operational training, exercises, medical activity support and actual platform support over a two-year period depicted in the figure 14. An overwhelming percentage of the requirements are in support of training and exercises. This alone emphasizes the need to ensure time spent away from the peacetime medical "benefit" is optimized. However, further review shows that the Bureau of Medicine and Surgery (BUMED) had assigned only 46.74% of those billets centrally. Military staff assigned by NMCP supported the remaining billets.

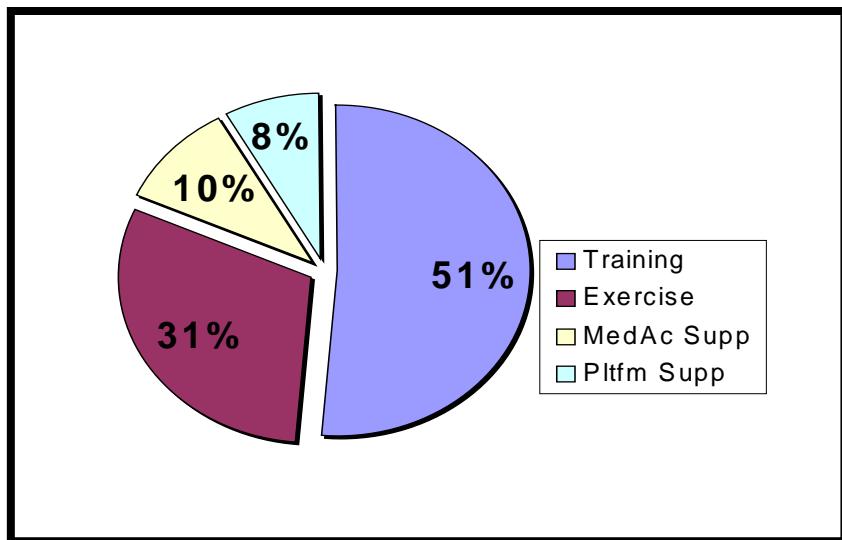


Figure 14 NMCP Support by Mission Type

Trending the requirements across time shows that the requirements are heavily weighted in the summer and early fall time frame. This time frame places NMCP at a disadvantage in trying to fill training and exercise requirements. Manpower is turning over and being indoctrinated at higher rates during this time frame limiting personnel available to fill the required billets. Many MTF commanders have become increasingly concerned with time spent away from day to day responsibilities (Boynton B. R., 2001).

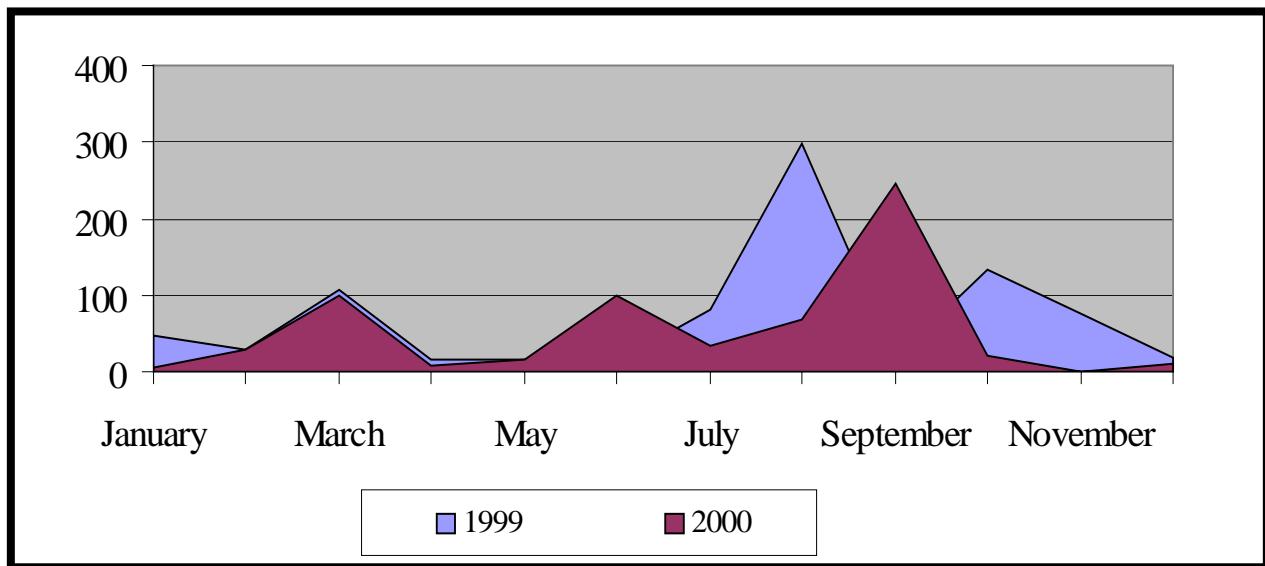


Figure 15 NMCP Operational Requirements

Navy Medical Department Readiness Education and Training. The Navy Medical Department as noted earlier relies heavily on an augmentation system to staff its operational platforms. However, medical readiness training and sustainment is based on a matrix of skill/course recommendations and requirements that do not provide the desired “stepped” approach of the JTS (United States Navy, Bureau of Medicine and Surgery, 2000). Additionally, it does not address or integrate all the desired components of FHP.

The Navy Medical Department uses a skill to course matrix the to assist commands in identifying training for personnel assigned to operational platforms. The assignment of medical

personnel is tracked and reported on the Medical Personnel Augmentation System Module (MPAS) of the Standard Personnel Management System (SPMS). While this system provides generalized statistics on readiness levels, it is scheduled for replacement because it is proprietary based and does not support MHS information systems standardization.

The current limitation of clear and progressive training requirements and appropriate analysis mechanism is an important discrepancy in light of the optimization effort. The targeted approach is not achieved due to lack of strategic control of the process. Managers who are responsible for carrying out the dual mission at the operational level do not have the appropriate tools they need to effectively develop readiness and support medical force integration.

The Navy's MAP Instruction denotes annual training requirements for the two major types of platform, i.e. shipboard and field medical units, and Nuclear Biological and Chemical weapon awareness and training. The instruction does not specify training physically onboard those platforms. Comparing training requirements at NMCP to the DOD Medical Skills Requirements Training Instruction (DODI 1322.24) shows that while annual days of training may be slightly under tasked, training on the actual platform is being over tasked looking at 3 year increments.

DOD Medical Skills Training <i>DODI 1322.24</i>		Medical Readiness Training 5 days/year	5 Days every 3 years on assigned platform
Billets Assigned	1,504	7,520	15,040
Billets Filled	703	3,515	3,515
Tasked with		6,431.5	12,863 (in 2 years)

Figure 16 Training Requirements

This is an important note because of the exponential effects on the peacetime mission. The amount of time spent on military and administrative medical requirements other than direct

care must be factored into the MTF capacity equation in the appropriate ratio. The optimization plan notes that these requirements are considered major operant variables to the MTF enrollment capacity (Military Health Services Optimization Plan, 2000). Unplanned and under budgeted requirements can drastically effect the day-to-day operations. Figure 17 shows that the provider and clinical support staff mix in requirements over a two year period. Prior to optimization efforts the typical MTF staffed providers to clinical support staff in a ration of 1:1.5. Current operational requirements take providers at a 1:2.88 ratio exacerbates the loss of normally productive staff.

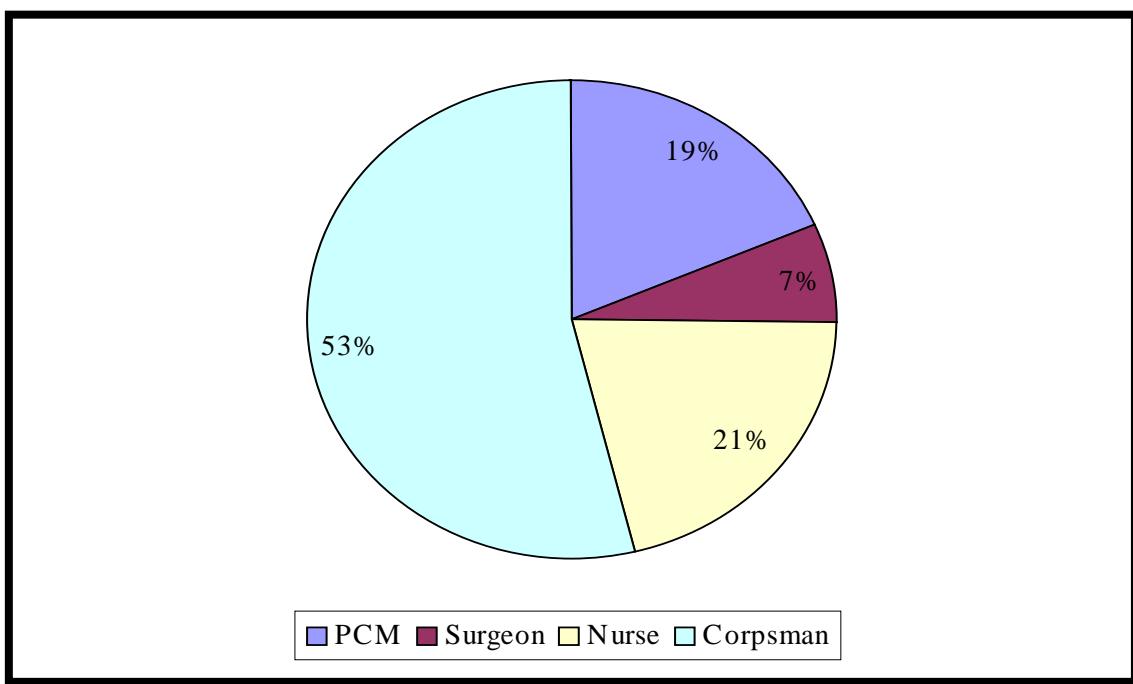


Figure 17 Operational Requirements by Staff Type

The time away from day to day operations in support of operational readiness is also compounded at NMCP by travel time and associated leave. Figure 18 shows that training and exercises are significantly affected by travel in access of 100 miles one way or air travel. Personnel often take leave and or are provided extra personal time in conjunction with these types of duty.

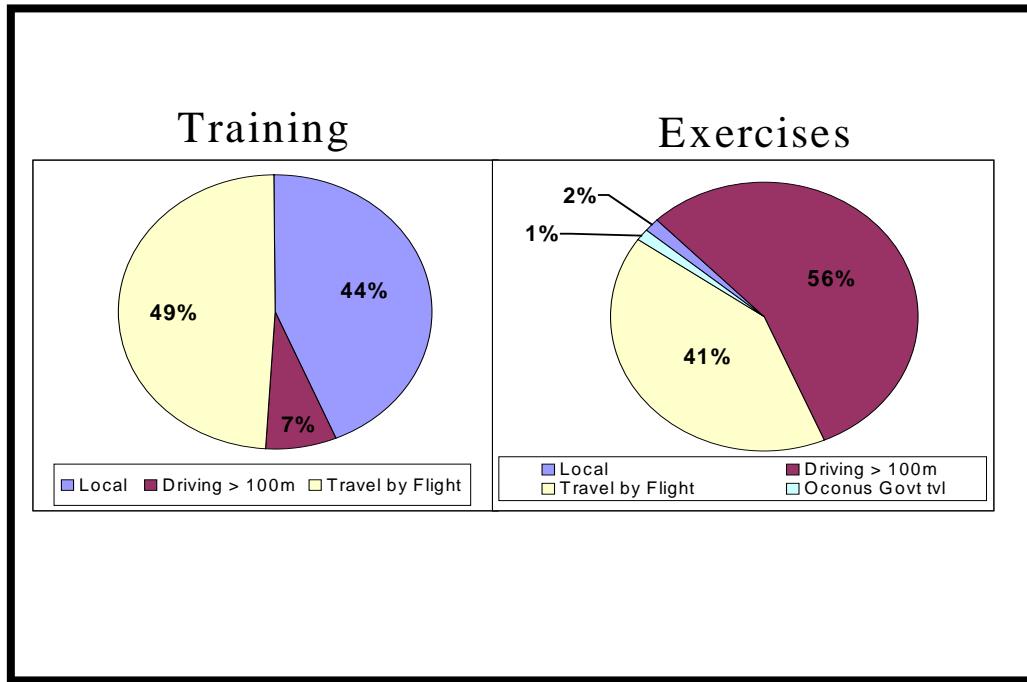


Figure 18 NMCP Distance from Missions

A review of how training is documented and carried out within a Navy Medical Department MTF demonstrates the value of alignment and standardization of training requirements. The Naval Medical Center Portsmouth's (NMCP) Readiness Training Program bases its readiness documentation on the MPAS module as required. This system's limitations prohibit the executive board and platform managers from easily getting a snapshot view of readiness levels or unit capability. Manipulation of the data to apply cost and trending analysis requires importing data tables to other database programs unless specific training in the "ADHOC" type of report generator is achieved and sustained. This manipulation is time consuming and lends itself to the use of corrupt or incomplete data.

As demonstrated, considerable time is devoted by NMCP to develop readiness, however, gaining insight on the cost of the development is critical in view of U.S. GAO concerns and the desire to streamline budgets. Figure 19 provides a rough calculation of costs associated with the development or sustainment of medical readiness. Travel to platform training and exercises; is

for the most part centrally funded. However, composite pay for personnel fulfilling these requirements is accounted for in the MTF Military Expense Reporting System and attributed to the MTF budget.

Average Travel & Per Diem	\$507.88
Average Composite Pay	\$2494.72
Last 2 Calendar Years Travel	\$800,411.97
Last 2 Calendar Years Pay	\$3,931,682.22

Figure 19 Readiness Development Costs

Considerable savings could be obtained across the Navy Medical Department and the MHS in both time and money by adopting the joint training and education strategies discussed earlier. Decentralizing the execution of what is considered redundant or sustainment training and only bringing personnel physically together for meaningful and valued added experiences also accomplishes the broad directional goals established in the FHP Doctrine and “operationalized” in the MRSP.

In essence, readiness for medical forces must be based on initial education and continued service training required under Title 10 USC and developed as joint venture in pursuit of the strategic change outlined in FHP. In doing so the Navy Medical Department platforms can then react appropriately to the missions across the operational spectrum. Incorporating the executive skills program, attaining the objectives of the MRSP and FHP will enhance the ability of the MHS to govern the operational side of the dual medical mission.

Conclusion and Recommendations

Readiness requirements are set according to capability needs of medical support to service and joint missions while fulfilling the peacetime mission. Therefore, the MHS must base its most efficient structure on defining, measuring and accomplishing these requirements or face severe restructuring (MHS Optimization Plan, 2000; Potter, 2000).

The desired level of integration among the service medical departments requires core common interoperable capabilities that support required joint capabilities. The Navy Medical Department can support the development of these capabilities and associated standards by aligning its governance structures with external ASD/HA organizations and adopting systematic processes that develop medical readiness. In doing so standardized processes in the development of readiness can be supported across the MHS optimizing its operational capability and developing synergy among medical departments.

The development the desired synergistic effect within the MHS today will focus strategies specifically as they relate to education and training, i.e. preparing the ready force in light of peacetime commitments. The MRSP outlines the objectives of readiness training; develop a systematic approach to readiness training; ensure interoperability; reduce redundancy and maximize economies of scale; and train to standard.

In defining the costing model, the MHS Optimization Plan is planning for current operations by maximizing the platform capabilities it has today, i.e. combat service hospitals, fleet hospitals, and air transportable hospitals. However, the capabilities must be redefined through retrenchment and enhancement processes. The joint education and training system approach, which develops the skills and defines requirements based on current and projected mission capabilities is necessary to develop strategic advantage for the MHS today. In doing so, the MHS and service medical departments can implement “commercial off the shelf system” approach that completes the readiness triad ensuring service readiness.

A medical readiness training system can be instituted by including the basic framework mentioned previously of the JTS and enacted within the revision of the Military Medical Skills Training Instruction (DODI 1322.24). An approved medical readiness training system would

present an interdependent series of stepped processes with a logical, doctrinally based approach that is designed to meet continually changing mission requirements and improve readiness across the operational spectrum. This effort will align the medical forces within the conceptual framework of today's war fighting commander. The original instruction establishes basic policies, i.e. rudimentary "field" skills and basic clinical skills along with minimal time frames for annual and refresher type mobilization training.

In support of the recommendations made by Healthcare Quality Review Panel and in answering the major concern of readiness study in the past decade the focus in the development of readiness for the medical forces should be standardized progressive training. In light of the research presented in this graduate project several recommendations can be made to Naval Medical Department and the MHS in general.

Recommendation 1. The MHS and Navy Medical Department should adopt and employ a PME/JPME type model specifically structured for medical readiness education.

Recommendation 2. The MHS and Navy Medical Department should adopt and employ a JTS like model to develop medical readiness training requirements.

Recommendation 3. The MHS and Navy Medical Department, as a continuance of MHS optimization, should target the decentralization of standardized medical readiness training.

Recommendation 4. The Navy Medical Department should develop a more specific medical readiness instruction that identifies standardized medical readiness training requirements as defined in the MRSP and FHP documents.

Recommendation 5. The Navy Medical Department should continue to consolidate training to eliminate real and perceived curriculum redundancy.

Recommendation 6. The Navy Medical Department should assign responsibilities that empower subordinate support commands to conduct, monitor and appropriately measure standardized development of medical readiness training.

Recommendation 7. The MHS and Navy Medical Department should further study the development of medical readiness identifying measures of effectiveness and assessing the appropriate annual phasing and career progression of training.

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Appendix A Timeline of Medical Readiness Guidance and Legislation

1980 Combat Casualty Care Course debuts based on congressional concerns. The Course focused on wartime readiness for physicians, which included filed medical systems, military health services capabilities, trauma care, and filed skills.

Code: 1ASD Impact Score: 1 Continuation Score: 1

1981 Joint Medical Readiness Education Council Formed to oversee joint medical training readiness training

Code: 2ASD Impact Score: 2 Continuation Score: 1

1986 GoldWater-Nichols Defense Reorganization Act & Title 10 require Joint Force Emphasis in Professional Military Education and Training

Code: 1CON Impact Score: 10 Continuation Score: 7

Joint Medical Education Center (JMRTC) formed in support of C4, the U.S. Army is named “lead agency”

Code: 3ASD Impact Score: 8 Continuation Score: 6

1987 GAO Report on Medical Readiness states that DOD had no standard system for measuring medical manpower readiness. There are major gaps between service medical requirements.

Code: 1GAO Impact Score: 2 Continuation Score: 1

1988 Medical Readiness Strategic Plan (MRSP) first published

Code: 4ASD Impact Score: 10 Continuation Score: 7

JMRTC becomes a Subordinate Command of Uniformed Service University of Health Sciences; Congress Mandates Exportable C4 Course

Code: 5ASD Impact Score: 8 Continuation Score: 7

1990 JMRTC Transferred to the U.S. Army Medical Department Center & School with no joint command designation.

Code: 1DOD Impact Score: 6 Continuation Score: 6

1992 GAO Report- Operation Desert Storm: Full Army Capability Medical Capability not Achieved "GAO/NSIAD-92-175"

Code: 2GAO Impact Score: 10 Continuation Score: 5

1993 Congress mandates "733 Study" part of the 1994 Defense Authorization Act finds that the Medical Departments are twice the size needed for two major regional conflicts.

Code: 2CON Impact Score: 10 Continuation Score: 6

Definition of Medical Readiness approved by DOD. "The ability to mobilize, deploy and sustain field medical services; to support any operation requiring military services; to maintain and project the continuum of healthcare resources required to provide for the health of the force; and to operate in conjunction with beneficiary healthcare."

Code: 2 DOD Impact Score: 8 Continuation Score: 4

GAO Report- Operation Desert Storm: Improvements Required in the Navy's Wartime Medical Care Program "GAO/NSIAD-932-189"

Code: 3GAO Impact Score: 10 Continuation Score: 5

1994 733 Study concludes Requirements for rendering Health Benefit greatly exceed readiness requirements

Code: 3CON Impact Score: 10 Continuation Score: 6

GAO Report-Operation Desert Storm: Problems with Air Force Medical Readiness "GAO/NSIAD-92-175"

Code: 4GAO Impact Score: 10 Continuation Score: 5

DOD IG Site Visit at JMRTC reviews C4 Program-Recommends significant program changes and command and control changes. Specifically training requirements are not well defined and little “joint training” conducted

Code: 3DOD Impact Score: 5 Continuation Score: 5

1995 Bottom-up Review Analysis of Key DOD Assumptions - CBO Reports that Medical Capacity can be decreased by 50%

Code: 4CON Impact Score: 10 Continuation Score: 8

GAO Report - Wartime Medical Care: Aligning Sound Requirements with New Combat Care Approaches Is Key to Restructuring Force GAO/T-NSIAD-95-129. The GAO reports that the 733 study's methodology is sound.

Code: 5GAO Impact Score: 10 Continuation Score: 9

GAO Report - Defense Health Care: Issues & Challenges Confronting Military Medicine "GAO/HEHS-95-104"

Code: 6GAO Impact Score: 9 Continuation Score: 8

MRSP Revised: Post Cold War Update 1995-2001. 12 Functional Areas: 1) Planning 2) Requirements, Capabilities, & Assessment 3) C4I Management 4) Logistics 5) Medical Evacuation 6) Manpower & Personnel 7) Training 8) Blood 9) Military Operations other than War 10) Nuclear, Biological , and Chemical Defense 11) R&D 12) Preventive Medicine

Code: 5ASD Impact Score: 8 Continuation Score: 7

Joint Medical (CINC) “Needs Analysis” After-Action Report & Consensus Recommendations responding to the DOD IG Report on JMRTC. An needs analysis of

Combatant Command Surgeons' need was conduct concluding in the perceived need for a focus on joint medical readiness training and MHS interoperability. It specifically identified courseware available through joint professional military education.

Code: 6ASD Impact Score: 9 Continuation Score: 7

DOD Military Medical Readiness Skills Instruction, DODI 1322.24 published outlining broad readiness requirements. It stipulated that the services shall ensure: All personnel should be trained to provide essential medical support, i.e. basic first aid. The services must also define skills & training requirements then assess, document, monitor, and report training in these areas. Healthcare personnel and units shall receive initial and sustainment readiness training; complete all service and command training requirements deployability within one year of military appointment, enlistment, or completion of initial occupational skill training. A period of basic training (or equivalent training) shorter than 12 weeks may be established. Training should focus first on early deployers; orientation to and performance at assigned mobilization billet. Training will be documented in reports and evaluations. There should be no less than 5 days of annual medical readiness training. Training will be made available for the reserves. Training with an individuals designated operational unit is required at least every three years for a minimum of five days.

Code: 7ASD Impact Score: 10 Continuation Score: 7

1996 National Defense Authorization Act Sec. 745. Study Regarding DOD Efforts to Determine Appropriate Force Levels of Wartime Medical Personnel. The models used by each military department for determining the appropriate wartime force level for medical personnel in the department. The study shall include the following:

- (1) An assessment of the modeling techniques used by each department.

(2) An analysis of the data used in the models to identify medical personnel requirements.

(3) An identification of the ability of the models to integrate personnel of reserve components to meet department requirements.

(4) An evaluation of the ability of the Secretary of Defense to integrate the various modeling efforts into a comprehensive, coordinated plan for obtaining the optimum force level for wartime medical personnel.

Code: 5CON Impact Score: 10 Continuation Score: 9

Joint Vision 2010 published - Shape Prepare & Respond through Dominant maneuver, precision engagement, full-dimensional protection, focused logistics

Code: 6DOD Impact Score: 10 Continuation Score: 10

GAO Report - Wartime Medical Care DOD Is Addressing Capability Shortfalls, but Challenges Remain GAO/NSIAD-96-224

Code: 7GAO Impact Score: 10 Continuation Score: 9

GAO Report Wartime Medical Care Personnel Requirements Still Not Resolved GAO/NSIAD-96-173

Code: 9GAO Impact Score: 9 Continuation Score: 9

GAO Report Peace Operations Reservists Have Volunteered When Needed GAO/NSIAD-96-75

Code: 8GAO Impact Score: 8 Continuation Score: 7

DOD IG Report - Evaluation Report on the Management of Combat Stress Control in the DOD

Code: 5DOD Impact Score: 9 Continuation Score: 4

DOD IG Report on DOD GME Programs & Medical Readiness Training # 96-

Code: 7DOD Impact Score: 9 Continuation Score: 7

Defense Medical Readiness Training & Education Council (DMRTEC) Chartered

Code: 8ASD Impact Score: 10 Continuation Score: 8

Inter-service Training Review Organization tasked to consolidate Medical Readiness Training

Code: 9ASD Impact Score: 9 Continuation Score: 8

1997 GAO Report Defense Health Care Medical Surveillance Improved Since Gulf War, but Mixed Results in Bosnia GAO/NSIAD-97-136

Code: 10GAO Impact Score: 8 Continuation Score: 8

DOD IG Report - Medical Readiness Training for Reserve Physicians #97-36

Code: 8DOD Impact Score: 9 Continuation Score: 4

MHS Executive Skills Curriculum Published – the medical readiness domain provides the following competencies and lists supporting behaviors: 1) Medical Doctrine; 2) Military Mission; 3) Joint Operations/Exercises; 4) Total Force Management; 5) National Disaster Medical Systems Management (NDMS)/Department of Veterans Affairs Role; 6) Medical Readiness Training; 7) Contingency Planning. The Medical Readiness Domain emphasizes the primary mission of the medical department executive's supporting role to the war fighter.

Code: 10ASD Impact Score: 10 Continuation Score: 10

1998 National Defense Authorization Act Fiscal Year 1998. Sec. 748. Comptroller General study of Navy graduate medical education program. Sec. 750. Comptroller General study of requirement for military medical facilities in National Capital Region.

Code: 6CON Impact Score: 10 Continuation Score: 8

GAO Report Medical Readiness Efforts Are Underway for DOD Training in Civilian Trauma Centers GAO/NSIAD-98-75

Code: 11GAO Impact Score: 10 Continuation Score: 10

GAO Report Defense Health Care: Collaboration and Criteria Needed for Sizing Graduate Medical Education GAO/HEHS-98-121

Code: 12GAO Impact Score: 9 Continuation Score: 9

GAO Report Defense Health Care Offering Federal Employees Health Benefits Program to DOD Beneficiaries GAO/HEHS-98-68

Code: 13GAO Impact Score: 8 Continuation Score: 8

1999 GAO Report Defense Health Care Tri-Service Strategy Needed to Justify Medical Resources for Readiness and Peacetime Care GAO/HEHS-00-10

Code: 14GAO Impact Score: 9 Continuation Score: 10

The Military Health System Optimization Team is chartered by and reports to MHS leadership to conduct research, coordinate working groups, integrate initiatives, and recommend strategies and operational plans to achieve the MHS vision.

Code: 11ASD Impact Score: 10 Continuation Score: 10

2000 Secretary of Defense shall prepare and submit to Congress a study identifying areas with respect to the Defense Health Program for which joint operations might be increased, including organization, training, patient care, hospital management, and budgeting. The study

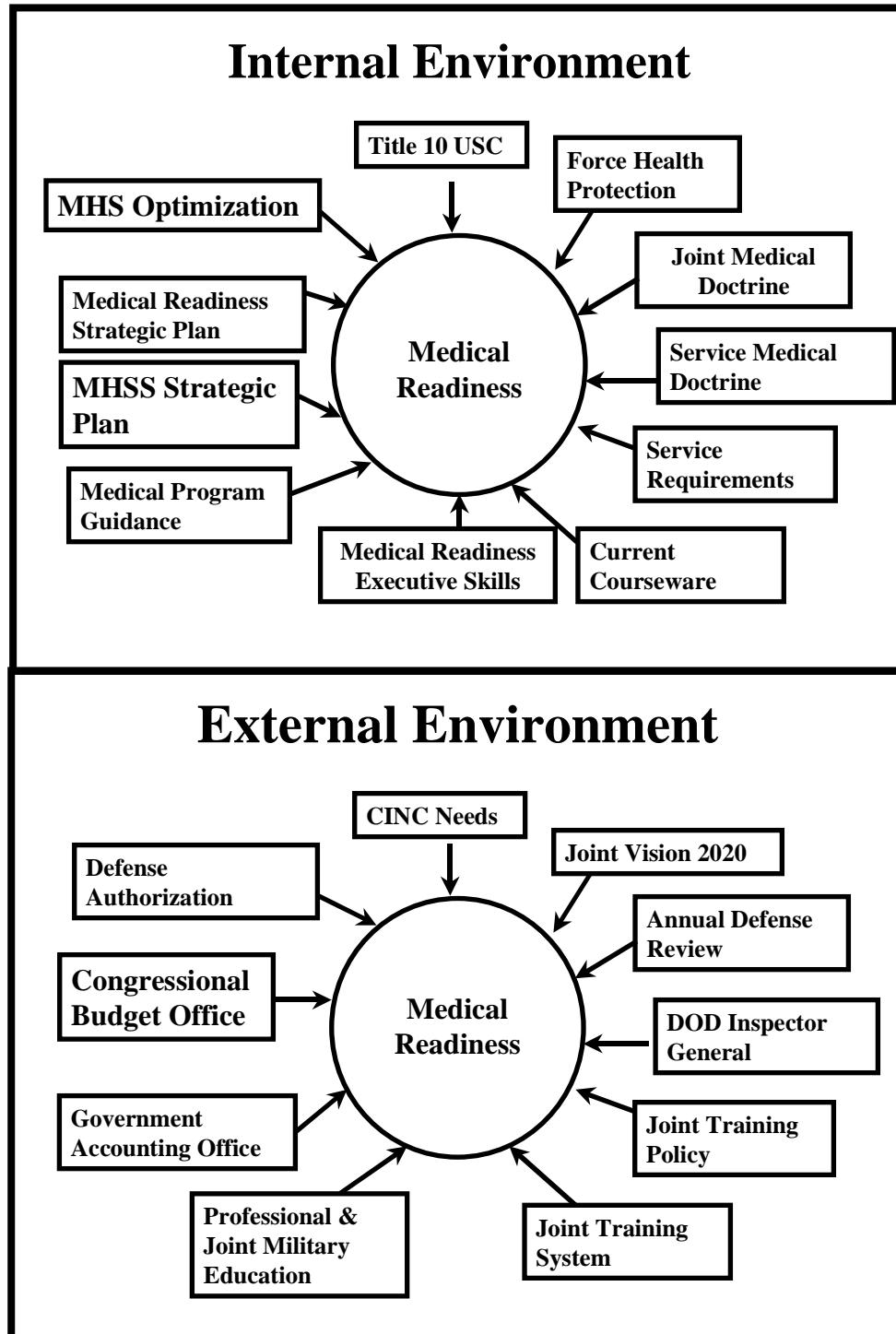
shall include a discussion of the merits and feasibility of: (1) establishing a joint command for the Defense Health Program as a military counterpart to the Assistant Secretary of Defense for Health Affairs; (2) establishing a joint training curriculum for the Defense Health Program; and (3) creating a unified chain of command and budgeting authority for the Defense Health Program.

Code: 7CON Impact Score: 10 Continuation Score: 10

FHP Capstone Document Published1) A Healthy Fit Force; 2) Casualty Prevention; 3) Casualty Care and Management

Code: 9DOD Impact Score: 10 Continuation Score: 10

Appendix B Medical Readiness Internal and External Environments



Appendix C MHS Strategic Plan

I. OVERVIEW

The Military Health System (MHS) is positioned to be the benchmark health care delivery system of the 21st Century, emphasizing readiness, health promotion, and managed care for all Armed Forces personnel, their families and others eligible for care. This strategic plan demonstrates the commitment of our Tri-Service teams to face, together, the challenges inherent in our changing roles and missions, as well as those being brought on by revolutionary changes within the health care community. These joint efforts support and promote collaboration, team building, and reengineering across the continuum to enhance quality, curb costs, and ensure access to all entrusted to our care.

By setting clear goals, preparing for possible eventualities, and assessing our resources and missions, we will be prepared to support both our operational and peacetime responsibilities. This "living document" will remain flexible while promoting a constancy of purpose for long-term strategic guidance. The mission, values, vision, goals, and strategies reflect our joint commitment to continuous improvement as we strive to integrate all aspects of this plan into our daily operations.

II. MISSION, VALUES AND VISION

Mission:

The Military Health System (MHS) supports the DOD and our nation's security by providing health support for the full range of military deployments and sustaining the health of members of the Armed Forces, their families, and others to advance our national security interests.

Values:

We are dedicated to the traditional military values of duty, honor, courage, and loyalty in service to our Nation. As members of the MHS, we are also faithful to the following values:

Integrity: Doing the right thing, for the right reasons, with credibility and candor.

Commitment: Selfless service, loyalty to others, and performance anchored by principle.

Caring: Compassion, regard, and respect for others - reaching out and treating others as we expect to be treated.

Excellence: Outstanding performance of duty characterized by technical and tactical proficiency, imagination, and innovation in a climate of continual learning.

Our values bind the organizations and individuals of the MHS. Every member of the MHS -- active, reserve, and civilian -- must understand and live by all of these values.

Vision:

- An enterprise providing health support for the Nation's security, the MHS:
- Fields a uniquely trained, equipped, and qualified team to meet the health needs of the fighting forces anytime, anywhere.
- Projects military health forces worldwide to advance our national security interests.
- Promotes a model health system valued by commanders, and all others we serve.
- Functions as an integrated and accountable health team.
- Develops leaders through continuous individual and organizational learning.
- Takes advantage of research and technology to advance health and readiness.
- Promotes health through the best practices of prevention and intervention.

III. GOALS AND STRATEGIES

GOAL 1—Joint Medical Readiness

We will help to ensure that military members of the Armed Forces attain an optimal level of fitness and health and are protected from the full spectrum of medical and environmental hazards. Our medical forces will meet the challenges of a rapidly changing continuum of Service-specific, joint, and combined military operations anywhere at anytime.

The continuum of military operations covers a myriad of medical readiness requirements. These requirements must be executed in an environment of increasing uncertainty and diminishing resources. The primary mission of the MHS is to ensure that our combatant commands have the most capable medical readiness support to meet their ever-changing mission. Our strategies must ensure that we are doctrinally prepared; can support operational requirements; and are well trained, resourced and ready to meet the challenges of our overall mission.

Strategies

- Strive to improve the health and fitness levels of our Armed Forces on a continuing basis.
- Deploy a doctrinally sound medical force that is well trained and equipped to accomplish its mission.
- Advocate research and technology that can optimize human performance and enhance force medical protection.

GOAL 2—Benchmark Health System

We will be the world's best integrated health system.

The MHS spans the continuum of health care from the operational and readiness mission to the delivery of the health benefit. To accomplish this, we must optimize use of the three Service medical departments to meet the MHS mission. Only in this way can we be health- and fitness-focused and responsive to customer needs where cost, quality, and access are paramount.

Strategies

- Communicate the TRICARE benefit so our customers will be educated and responsible consumers.
- Promote prevention and wellness as the foundation of the system.
- Deliver state-of-the-art, outcome-oriented, compassionate care.
- Measure health outcomes and customer satisfaction to identify opportunities for improvement.
- Measure MHS leadership, management, and technical skills.

GOAL 3—Healthy Communities

We will forge partnerships to create a common culture that values health and fitness and empowers individuals and organizations to actualize those values.

The complexity and tempo of military operations requires optimal human performance (reflecting complete physical, mental, and social well-being). In addition, diminishing resources must be targeted to maintain and promote healthy individuals, workplaces, and communities.

Strategies

- Utilize comprehensive, population-based, medical information systems as a foundation for evidence-based disease prevention and health decision making.
- Develop partnerships among the MHS, other Government agencies, and the private sector to create healthier environments and workplaces.
- Provide necessary health information to commanders, policy makers, and individuals who can act to influence health and prevent diseases and injuries.
- Sustain the prevention culture at home and abroad, in peace and war.

GOAL 4—Resources and Structure

We will identify and prioritize resource requirements and establish effective and efficient organizations to support the readiness and benefit missions. The identification and prioritization of resource requirements and efficient organizations is critically important to the ultimate acquisition of resources to support MHS programs.

Strategies

- Identify and resource medical readiness requirements to meet the rapidly changing continuum of military operations.
- Develop and use analytical models to determine resource requirements for manpower, education and training, facilities, materiel, and equipment.
- Use cost/benefit analysis to determine when outsourcing and privatization are appropriate alternatives for achieving the MHS mission.
- Use best-practice models to achieve maximum efficiencies.
- Employ organizational structures that best support the readiness, efficiency, and effectiveness of the MHS.

GOAL 5—Training and Skills Development

We will train and develop our people for their roles in war and peace. Well-trained people are the bedrock of a successful health system. Achieving our strategic goals will require developing plans to educate, train, and retain highly qualified and diverse personnel at all levels of the system.

Strategies

- Provide an integrated system of education, training, and professional development to produce skilled leaders and managers at all levels.
- Provide education and training programs to maximize the quality of the medical force.
- Establish requirements-based training criteria to support the MHS mission.
- Pursue opportunities to consolidate, integrate, privatize, and/or outsource training programs.
- Encourage and support a policy of inclusion and advancement for persons representing a variety of backgrounds.
- Promote technology and innovation for education and training.

GOAL 6—Technology Integration

We will integrate technologies into best practices designed to achieve high quality clinical outcomes, decrease health care delivery costs, and improve management processes. To obtain the full benefit of new technology, we are committed to a value analysis of all requirements. For the integration of new technology to truly succeed, we must provide a measurable performance result that is connected to improvement, increased efficiency, information dominance, and mission accomplishment.

Strategies

- Identify the full range of technologies needed to accomplish the MHS mission.
- Plan for, assess, obtain, install, and maintain technologies to provide cost beneficial, interoperable solutions to meet MHS requirements.
- Train to insert and sustain new technologies.

THE PLAN REVISION PROCESS

The initial strategic plan for the MHS was published in May 1995. The forum and the Hoshin Planning Methodology used in the development of that document were maintained. Some changes in personnel have occurred, but the process has remained intact. This process is

the mechanism by which the guiding members of the MHS envision its future and develop the necessary procedures and operations to attain that future.

In March 1997, the strategic planning workgroup embarked on the first revision of the strategic plan. At that time, the workgroup felt there was sufficient impetus to support a re-look at the original MHS Strategic Plan. This impetus came from a number of sources. First, there was a charge from the Executive Members of the Strategic Planning Committee to reevaluate the plan. Second, there was input from the MHS 2020 initiative. This was an extensive futures exercise that peered 25 years into the future. It was a one-year effort that involved over 200 military and private-sector health professionals, along with world-renowned futurists. This process developed four alternative futures and traced 10 critical elements through each of these futures. The group then addressed what near-term steps could be taken that would facilitate the realization of a preferred future rather than merely waiting for the future to happen. Part of the charter of this group was to evaluate the MHS Strategic Plan to see whether it provided the near-term stepping stones toward the preferred future. The group provided valuable input to the strategic planning process. Finally, there was feedback from the February 1997 TRICARE Conference where two focus groups convened and provided responses to specific questions regarding the MHS Strategic Plan.

The workgroup reviewed and incorporated this input/feedback to produce an initial draft revised plan. The draft, though similar in content to the first plan, had some significant differences, including a Statement of Values, that was strongly recommended by the MHS 2020 initiative. Additionally, the workgroup felt the need to break out the concept of health and fitness into a separate goal. The draft went through two additional feedback iterations with the field before finalization. The MHS leadership felt strongly that feedback was essential to elicit ownership and buy-in from the field.

MAJOR STRENGTHS, WEAKNESSES,

OPPORTUNITIES, or THREATS CONSIDERED

The workgroup reviewed all activities related to internal and external factors that had been accomplished for the initial strategic plan. In reviewing the environment to be considered, a multitude of internal and external factors were identified. They were classified into categories of major strengths, weaknesses, opportunities, or threats (SWOT), which helped the workgroup to focus effectively on key areas of concern.

The workgroup sought to prioritize these categories in order to best focus their attention on the key issues. Throughout the plan, emphasis was continually placed in the following major areas:

- Readiness—utilizing joint operations and reserves
- Wellness versus illness
- Managed Care growth—Lead Agent role

- Changes in medical care focus from specialty to primary care
- Technology and business process improvements—outcomes measurement, planning
- Changes identified in mission
- Change in resourcing focus
- Health and fitness

Even after drafting the goals for the MHS, during the development of strategies for particular breakthrough issues, the group continued to consistently identify the above areas for ongoing attention. The interdependency between all these areas has been identified throughout the workgroup's activities and has reinforced the original SWOT activities and the focus for the future.

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Appendix D Navy Medical Department Strategic Plan

Mission:

As the Medical Department of the United States Navy, we:

- Support the deployment readiness of the uniformed services
- Promote, protect and maintain the health of all those entrusted to our care, anytime, anywhere

Our Vision:

Superior readiness through excellence in health services.

Our Guiding Principles

We believe:

- The Navy's Core Values are the bedrock of Navy Medicine.
- Health is a state of physical, mental, spiritual and social well being, not simply the absence of disease.
- Our people are our most important resource and their dignity, worth and cultural diversity are invaluable assets.
- Quality health care must be provided in an atmosphere of service, professionalism, compassion, teamwork, trust, and respect.
- Our success will be judged by our customers.
- Meeting the unique needs of the Navy and Marine Corps is vital to our success.
- Continuous improvement must permeate all aspects of our enterprise.
- Working jointly with other active and reserve medical personnel will achieve more effective results
- Navy Medicine must be run effectively and responsibly based on sound business practices.
- Education and research are the foundation of our future.

Force Health Protection

As outlined in the DOD Medical Readiness Strategic Plan (MRSP), the military medical departments exist to support their combat forces in war; and in peacetime, to maintain and sustain the well being of the fighting forces in preparation for war. The medical departments must be prepared to respond effectively and rapidly to the entire spectrum of potential military operations – from major regional contingencies to Military Operations Other Than War (MOOTW)

Readiness to support wartime/contingency operations will require us to successfully accomplish several missions simultaneously. We must be able to identify the medical threat; develop medical organizations and systems to support potential combat scenarios; train medical units and personnel for their wartime roles. We must train non medical personnel in medical subjects; conduct medical research to discover new techniques and materiel to conserve fighting strength; and provide both preventive and restorative health care to the military force.

Force Health Protection is a strategy that maintains readiness by promoting a system of comprehensive quality health services that ensures our people are fit and healthy; that they are protected from hazards during deployment; and that when illness or injury intervenes, they are afforded state of the art casualty care.

Goals	Objectives
Goal: Optimize the health and fitness of the total force	<p>Military personnel have current health evaluations used to improve their health</p> <p>Sailors and marines are healthy and fit</p> <p>Medical dispositions are timely and appropriate</p> <p>Sailors and Marines have dental health</p> <p>R&D focused on enhancing readiness through research, development, testing and evaluation of products to enhance the health, safety, and performance of the force</p>
Goal: Minimize casualties through effective prevention and surveillance	<p>Military personnel have required immunizations that are properly documented</p> <p>Personnel monitored and protected from preventable/predictable disease and injury</p> <p>R&D is focused on drugs, vaccines, etc., and surveillance/evaluation of occupational and environmental risks to prevent or minimize casualties</p>

<p>Goal: Maximize readiness to deliver effective casualty care anywhere, every time</p>	<p>Tier one deployable platforms are ready</p> <p>Active and Reserve medical department personnel are administratively ready for their contingency roles</p> <p>Active and Reserve medical department personnel are trained for contingency roles</p> <p>R&D is focused on improving casualty care as indicated by efforts to deliver products which improve the effectiveness of first responders and to improve the effectiveness of delayed therapy to enhance long-term survival</p>
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People	
Goals	Objectives
<p>Enhance Job Satisfaction and career development: Job satisfaction and career development are essential elements in recruiting, retention and development of a professional, career oriented Medical Department.</p>	<p>Effective leadership and mentoring exists at all levels of the organization.</p> <p>Our personnel embrace the mission and understand their role in accomplishing it.</p> <p>Our personnel are satisfied with professional development, skill utilization and career progression.</p> <p>Navy Medicine will retain and attract talented and motivated personnel</p>
<p>Train to Requirements: Navy Medicine aligns and trains its military, civilian and contract partners to support the Navy's mission</p>	<p>All Navy Medicine billets and positions are aligned with the Navy's mission.</p> <p>Navy Medical Department training is aligned with the Navy's mission and optimization of health</p>

The Health Benefit

The complementary partner to Navy Medicine's readiness mission is the health benefit mission. As we approach the 21st Century, fundamental changes continue to occur in the way health services are organized, delivered, and paid for, in both civilian and military sectors. Today, all health plans and providers are competing on the traditional bases of access, quality and cost. An intrinsic element that distinguishes the truly outstanding programs from the rest is the level of health outcomes the system achieves for its beneficiaries. Thus, just as health and fitness are critical barometers of the readiness of our Navy-Marine Corps forces, so too is the health and fitness of our extended military family. This family includes the spouses and children of our active members, and our retirees, their family members or survivors – their health is a critical barometer of the performance of our health system.

The TRICARE Prime Program enables us to focus on managing the health of a defined population of enrollees and, to the degree possible, to provide preventive services rather than simply intervene when disease or injury occurs. Assignment of our TRICARE Prime enrollees to Primary Care Managers, through whom access is guaranteed within specific time and distance standards, fosters continuity of care while eliminating the uncertainty of space available care with an unknown provider. Our patients now have a choice. If Navy Medicine is to be the provider "of choice" for our military family, our performance in achieving high quality outcomes in health status, access, customer satisfaction, and low cost must be superior. It is within this framework that the Health Benefit Goals and Objectives have been created.

Health is a precious asset. Our responsibility is to enhance and maintain the health of our beneficiaries. Prevention is so much better than intervention, early diagnosis superior to late recognition of a curable disorder no matter how good the treatment. We must consider the wellness of our population to be the most important asset we have – one that is free but easily squandered, never to be recovered.

Goals	Objectives
Communicate the benefit and educate our customers	<p>Inform customers: beneficiaries will be knowledgeable about and confident in their health benefits.</p> <p>Inform staff: Navy Medical Department staff will be knowledgeable emissaries for TRICARE and other DOD health services.</p> <p>Prepared leadership: medical leadership will communicate information about current issues to their beneficiaries, staff and line organizations.</p> <p>Informed leaders: military and civilian leadership will be knowledgeable about the health benefit and the readiness mission of the Navy Medical Department.</p>

<p>Provide quality preventive and restorative services</p>	<p>Quality: beneficiaries will receive the highest quality health services.</p> <p>Health focus: beneficiaries will receive services that are focused on improving health and avoiding illness.</p> <p>Access: beneficiaries will have timely access to services, assistance, and information.</p>
<p>Identify and implement clinical business strategies</p>	<p>Utilization and risk management: we will maintain comprehensive utilization management and risk management programs.</p> <p>System wide practice guidelines: selected clinical practice guidelines will be universally implemented throughout Navy Medical Department facilities and adapted to local requirements.</p> <p>Professional network: we will maintain a professional communication system to share experience, information and ideas.</p> <p>We will simplify the delivery of the health benefit.</p>

Best Business Practices

We in Navy Medicine must carry out our mission as a business, recognizing the readiness, social, personal, professional and economic impacts of our decisions. This goal group demonstrates clearly our commitment to achieving best value in all that we do as we apply our resources, capabilities, skills and technology in striving to attain benchmark status.

A key to both our near and long-term success is the employment of sound business practices throughout Navy Medicine. The practices should focus on a desired end state, outcome, result or product that allows us to realize our vision of "Superior readiness through excellence in health care services." These practices affect the entire spectrum of our activities - clinical care, forward-deployed medical care, education and training, research and development, finance, logistics, information management, facilities maintenance and administration. It is through this exemplar of Best Business Practices that Navy Medicine fulfills its accountability for stewardship to those entrusted to our care and to the American people.

Goals	Objectives
<p>Identify and be the benchmark for sound business practices</p>	<p>Navy Medicine's consistent, complete, relevant, timely and reliable cost and workload data will be the benchmark for the MHS.</p> <p>Best business practices will result in best value, indicated by increased market share, reduced cost, reduced cycle time, improved quality, increased productivity, and/or return on investment.</p>

	<p>Best business practices will be rapidly implemented throughout Navy Medicine through a standard process.</p>
Identify, acquire and integrate technologies that have the greatest benefit	<p>New technologies will be integrated within Navy Medicine through a standard process that evaluates their contribution to readiness, quality, access, interoperability, costs, and customer expectations</p> <p>New technologies selected for integration in Navy Medicine are acquired and delivered according to plan.</p> <p style="background-color: yellow;">We will “web-ify” Navy Medicine to improve health and business practices.</p>

Best Practice: A practice that has been shown to produce superior results; selected by a systematic process; judged as exemplary, good, or successfully demonstrated; and adapted to fit a particular organization.

Appendix E SWOT Matrix

Future Quadrant Related Diversification Vertical Integration Market Development Penetration	Internal Fix it Quadrant Retrenchment Enhancement Market Development Product Development Vertical Integration Related Diversification
External Fix it Quadrant Related Diversification Unrelated Diversification Market Development Product Development Enhancement Status Quo	Survival Quadrant Unrelated Diversification Divestiture Liquidation Harvesting Retrenchment

Appendix F PME and JPME Curriculum

THE OFFICER PROFESSIONAL MILITARY EDUCATIONAL FRAMEWORK

1. Overview. The Officer Professional Military Educational Framework (see Figure A-B-1) reflects the dynamic system of officer career education. It identifies areas of emphasis at each educational level and provides joint curriculum guidance for PME institutions. It is a comprehensive frame of reference depicting the sequential and progressive nature of PME. The framework illustrates development of Service and joint officers by:
 - a. Identifying five military educational levels—pre-commissioning, primary, intermediate, senior, and general/flag.
 - b. Portraying the primary focus of each educational level in terms of the major levels of war--tactical, operational, and strategic.
 - c. Linking educational levels so each builds on knowledge gained at previous levels.
 - d. Recognizing both the distinctiveness and interdependence of joint and Service schools in officer education.
 - (1) In conjunction with Service-unique education, Service schools provide joint education primarily from a Service perspective in accordance with joint learning areas and objectives.
 - (2) Joint schools provide joint education from a joint perspective.
2. PME Relationships
 - a. PME entails the systematic instruction of professionals in subjects enhancing their knowledge of the science and art of war. The PME system is a progressive, cumulative process, preparing officers for duty at each successive level of responsibility within the levels of war. The PME system produces:
 - (1) Officers educated in the profession of arms.
 - (2) Strategic thinkers who view events in a historical, political, social, economic, informational, techno-logical, and military context and are capable of identifying and evaluating likely changes and associated responses affecting US military strategy, theater strategy, and campaigning.
 - (3) Senior officers who can integrate national military strategy with national security strategy and policy ensure effective employment of the Armed Forces in implementing national security policy.
 - b. JPME is that portion of PME concentrating on the instruction of joint matters in order to:
 - (1) Provide officers a broad base of joint professional knowledge.
 - (2) Develop officers whose experience and education improve the strategic and operational capabilities of joint forces across the range of military operations.
 - (3) Instill knowledge of the broad joint warfare concepts embodied in Joint Pub 1, “Joint Warfare of the Armed Forces of the United States” (reference e) and the specific concepts found throughout the range of military operations and codified in other joint doctrine.
 - (4) Develop officers skilled in attaining unity of effort across Service, interagency, non-governmental, and multinational lines.
 - c. PJE is that portion of JPME that qualifies officers for JSO nomination. Frequently shared PJE curricula areas include warfighting and national and international (regional) considerations as they affect the formulation of national security policy, the roles of the DOD and

the Services, military history, military strategy, leadership skills, and analytical techniques.

d. During the course of their careers, officers continue to undertake educational programs not specifically defined as ILCs or SLCs. These programs span several levels of education.

3. Structure of the PME Framework

a. PME Levels. The framework relates five military educational levels to five significant phases in an officer's career.

(1) Precommissioning. Military education received at institutions and through programs producing commissioned officers upon graduation.

(2) Primary. Education typically received at grades O-1 through O-3.

(3) Intermediate. Education typically received at grade O-4.

(4) Senior. Education typically received at grades O-5 or O-6.

(5) General/Flag Officer. Education received as a G/FO.

b. Levels of War. The framework portrays the primary focus of each educational level in relation to the tactical, operational, and strategic levels of war as outlined in the UJTL (reference d). It recognizes that PME curricula educate across levels of war.

c. Precommissioning- and Primary-Level Education. Appendix A to Enclosure C outlines education at the precommissioning and primary levels.

d. Intermediate-Level Education

(1) Institutions and Courses

(a) Service Intermediate-Level PME Institutions

1. Air Command and Staff College (ACSC).

2. Army Command and General Staff College (USACGSC).

3. College of Naval Command and Staff (CNCS).

4. Marine Corps Command and Staff College (MCCSC).

5. Naval Postgraduate School (NPS), Joint Education Electives Program (JEEP).

6. Service college nonresident courses.

7. Recognized equivalent fellowships and international military colleges.

(b) AFSC is the sole joint intermediate institution offering PJE Phase II in its Joint and Combined Staff Officer School (JCSOS). Per title 10, USC, section 663 (reference b), JCSOS "may not be less than three months."

(2) Focus. Intermediate-level education focuses on war-fighting within the context of operational art. Students expand their understanding of joint force employment at the operational and tactical levels of war. They gain a better understanding of joint and Service perspectives in theater warfare. Inherent in this level is development of an officer's analytic capabilities and creative thought processes. In addition to continuing development of their combined arms expertise, they are introduced to theater strategy and plans, national military strategy, and national security strategy and policy.

(3) Joint Emphasis (PJE Phase I--Intermediate Level). Service ILCs teach subordinate joint operations from the standpoint of Service forces in a joint force supported by Service component commands. Joint curricula emphasis at this level includes:

(a) National military capabilities and command structure.

(b) Joint doctrine.

(c) Joint and multinational forces at the operational level of war.

(d) Joint planning and execution processes.

(e) Systems integration at the operational level of war.

(4) Joint Emphasis (PJE Phase II--Intermediate Level). AFSC examines joint operations from the standpoint of the Joint Chiefs of Staff, a unified commander, and a joint task force (JTF) commander. It further develops joint attitudes and perspectives, exposes officers to and increases their understanding of Service cultures while concentrating on joint staff operations. Its curriculum is specifically joint and accomplishes the following:

(a) Increases and applies knowledge gained in a Phase I program.

(b) Addresses joint staff operations in detail.

e. Senior-Level Education

(1) Institutions and Courses

(a) Service Senior-Level PME Institutions

1. Air War College (AWC).

2. Army War College (USAWC).

3. College of Naval Warfare (CNW).

4. Marine Corps War College (MCWAR).

5. Service college nonresident courses.

6. Recognized equivalent fellowships and international military colleges.

(b) Joint Senior-Level PME Institutions

1. NWC.

2. ICAF.

3. AFSC's Joint and Combined Warfighting School (JCWS).

(2) Focus. As drawn from Joint Pub 1-02, "DOD Dictionary of Military and Associated Terms" and Joint Pub 3-0, "Doctrine for Joint Operations" (references f and g), strategy is the art and science of developing and using diplomatic, economic, military, and informational instruments of national power as necessary during peace and war, to afford the maximum support to policies, in order to increase the probabilities and favorable consequences of victory and to lessen the chances of defeat. Studies at these colleges should emphasize analysis, foster critical examination, encourage creativity, and provide a progressively broader educational experience.

(a) Service SLCs. Service SLCs focus on national military strategy as derived from national security strategy and policy. Theater level strategy, campaign planning, and warfighting are part of their curricula. Senior military leadership roles include not only an understanding of the military arena, but of the diplomatic, economic, informational dimensions of the theater strategic environment affecting strategy formulation and implementation.

(b) Joint SLCs

1. NWC's senior-level JPME curriculum focuses on national security strategy--the art and science of developing, applying, and coordinating the instruments of national power (diplomatic, economic, military, and informational) to achieve objectives contributing to national security. NWC graduates satisfy the educational requirements for JSO qualification.

2. The ICAF curriculum offers senior-level JPME and focuses on the resource component of national power and its integration into national security strategy. ICAF graduates satisfy the educational requirements for JSO qualification.

3. AFSC provides a 3-month PJE Phase II (Senior-Level) education.

(3) Joint Emphasis. The Service SLCs provide an initial PJE stage (Phase I) of senior-level JPME. AFSC provides a follow-on PJE stage (Phase II) of senior-level JPME for selected

graduates of Service SLCs that develops joint attitudes and perspectives, and hones warfighting skills. NWC and ICAF are fully joint, full-length programs with separate, unique programs reflective of their distinct educational focuses. The following defines joint curricula focus at the senior level.

- (a) National security strategy.
- (b) National planning systems and processes.
- (c) National military strategy and organization.
- (d) Theater strategy and campaigning.
- (e) Systems integration in 21st century battlespace.

f. Education at the G/FO Level

(1) Courses

(a) Capstone. NDU conducts this required course for all Active component, and when feasible, Reserve component officers promoted to G/FO rank.

(b) Joint and Service Seminars and Courses. These include courses such as the Joint Flag Officer

Warfighting Course conducted by the Service Chiefs and the Joint Forces Air Component Commander Course offered by the US Air Force.

(2) Focus. Education at the G/FO level is inherently joint and unified in nature. Its focus is on the highest levels of strategy, integrating the elements of national power to achieve national security objectives. In particular, the Capstone Course reinforces new G/FO comprehension of joint matters and national security strategy needed for the remainder of an officer's career.

Appendix G to Enclosure C outlines education at the G/FO level.

4. PME Flow. Except for PJE requirements for JSO qualification, officer development and progression through the PME framework is a Service responsibility. For JSO qualification, an officer optimally completes PJE requirements prior to or within the first year of a joint duty assignment (JDA) posting. The Joint Staff (J-7), acting as an advocate for CINCs' requirements; the Services; and NDU coordinate PJE Phase II student flow.